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HEALTH HAS NO BORDERS: ADDRESSING GLOBAL HEALTH IN THE NETHERLANDS

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CONTENTS

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DAH	Development Assistance for Health
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GNI	Gross National Income
GPG	Global Public Good
HIV	Human Immunodeficiency virus
HPV	Human Papillomavirus
HSS	Health System Strengthening
IMF	International Monetary Fund
IPR	Intellectual Property Rights
LGBT	Lesbian, Gay, Bisexual and Transsexual
LSH	Life Science and Health
MDG	Millennium Development Goals
MERS	Middle East Respiratory Syndrome
MIC	Middle Income Countries
NCD	Non-Communicable Diseases
NCDO foundation	Dutch knowledge and advisory centre for citizenship and international cooperation
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
PDP	Product Development Partnership
R&D	Research and Development
RIVM	National Institute for Public Health and Expenditure
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TTIP	Transatlantic Trade and Investment Partnership
UHC	Universal Health Coverage
UN	United Nations
WDR	World Development Report
WHO	World Health Organisation
WRR	Dutch Scientific Council for Government Policies

1. INTRODUCTION

The Ebola outbreak was a wake-up call; it made clear that a health problem occurring in one particular part of the world – Guinea, Sierra Leone and Liberia in West Africa - can spread around the globe easily because of the transnational movement of people. The fear of an outbreak of Ebola was thus not only felt in the countries where many people succumbed to the disease, but also in other parts of the world. The Ebola outbreak was not the first wake-up call. In recent history, there have been other 'global diseases', such as the Middle East Respiratory Syndrome (MERS), the Severe Acute Respiratory Syndrome (SARS), the H1HN influenza virus, and AH5N1 virus, transmitted by birds, which proved that infectious diseases rapidly 'travel' all over the world. They can be transmitted by people, animals, as well as food.

Infectious diseases are not the only global health challenges that the world faces today. In developing countries persistent malnutrition and poverty-related illnesses such as diarrhea are still of paramount concern. And notwithstanding international efforts to improve maternal, newborn and child health, there are still 800 pregnancy and childbirth-related maternal deaths every day worldwide. An astonishing number of 750 children under the age of five die every hour, mostly of preventable causes. At the same time, 'diseases of affluence', such as diabetes and heart attacks, are threatening lives around the world, with the number of overweight people in developing countries quadrupling over the last 30 years (Keats & Wiggins, 2014). In other words, the borders between countries are fading when it comes to health. Similar health issues are affecting people in countries all over the world, while the gaps between poor and rich and rural and urban citizens within countries are growing.

Several reports have highlighted the importance of investing in health worldwide. One of the most influential reports was the World Development Report (WDR) 'Investing in Health' published in 1993. The Lancet commission on Investing in Health drew from the WDR report and in 2013 published the report 'Global Health 2035: A World Converging within a Generation', hereinafter referred to as 'Global Health 2035. Both reports emphasize that investments in health are important to improve public health and prevent illness, while people's enhanced health at the same time influences economic outcomes in terms of productivity, labour supply, human capital and public spending. 'Global Health 2035' argued that within a generation—by 2035—the world could achieve a 'grand convergence', due to investments in health, which would bring preventable infectious diseases, maternal and child deaths down to universally low levels.

This report focuses on the implications of 'Global Health 2035' for the discussion and policies on global health and its possible implications for Dutch policies in the field of global health. The Netherlands has a reputation as a frontrunner in development cooperation. Sexual and Reproductive Health and Rights (SRHR) have been one of the policy priorities. It is also an international trade hub and hosts prominent companies that focus on healthcare. The Netherlands does not have a global health strategy like, for instance, Sweden and the United Kingdom. It is therefore interesting to explore how global health is on the agenda of the Netherlands. Discussions and policies about global health are linked to wider debates about the future of development cooperation and poverty alleviation, as well as global sustainability challenges, which all come together under the umbrella of the future international agenda for international cooperation; the Post-2015 agenda. The Millennium Development Goals (MDGs) placed a strong emphasis on health, mainly by focusing on improving healthcare for mothers and young children and the prevention of diseases such as HIV and Aids and malaria. It is expected that the international community will agree on a new set of goals at the end of this year. The proposed goals include a goal focusing on ensuring healthy lives and promoting

well-being for everyone at all life stages. This indicates the continued relevance of health concerns in the future development agenda.

According to the World Health Organization (WHO), health is "the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[1] According to the WHO, achieving the highest possible health status is a fundamental human right. Traditionally, development issues related to health fall within the field of knowledge of experts in tropical healthcare, health systems and public health. Many health links with other policy fields like housing, safety and education have also been acknowledged (WHO& Commission on social determents of health, 2008). Due to globalisation and such links, health issues are also increasingly transnational (The Lancet Commissions, 2013; Van de Pas, 2014).

Box 1. What is global health?

When do we start talking about *global* health? Or to put it differently, when is health an issue of global concern? There is no agreement in the literature on what global health entails. Based on 'Global Health 2035' and Van de Pas 2014, we argue the specific focus of global health is connected to:

1. Transnational health themes; health issues are interlinked due to globalisation and transnational linkages. As people travel and goods are transported, 'health issues' travel along with them.
2. Worldwide health challenges such as high mother and child mortality rates, the access to birth control and the number of people affected by diseases like malaria, which are to be found in many parts in the world and as such can be considered global health issues.

Many other issues of global importance such as climate change, safety, urbanisation, trade and food security are also connected to health. For instance, diabetes, cancer and obesity are health challenges that can be caused by specific consumption patterns and changing lifestyles worldwide that have become increasingly similar to western lifestyles. They are of increasing concern to people all over the world, including in lower and middle-income countries.

Health experts have argued that health challenges should also be addressed at a global level (Bozorgmehr, 2010). However, healthcare has mainly been organised at a national level by national governments, while international institutes currently do not seem to be well enough equipped to address the 'globalisation' of health issues (Van de Pas 2014; Van Ewijk, 2014). This report focuses on Dutch government policies in the field of global health issues and includes the views of Dutch global health professionals, as well as opinions of Dutch citizens about the importance of Dutch support for global health issues.

Guide to the report

Chapter two presents the main conclusions of the Lancet report 'Global health 2035; a world converging within a generation' and discusses the international reception of the report. Chapter three presents a short overview of the evolution in Dutch thinking and policies regarding (global) health and development cooperation and provides an analysis of the current Dutch global health policies, also in relation to those of other European donors. Chapter four discusses to what extent and how global health is on the agenda of the Netherlands and provides a discussion on the implications of 'Global Health 2035' for Dutch policy making, based on interviews with key experts in the field of global health in the Netherlands, as well as some experts from international organisations. Desk research was

[1] WHO Terminology Information System [online glossary] http://www.who.int/health-systems-performance/docs/glossary.htm

carried out in order to provide context to the findings. The attitudes to and knowledge of the Dutch with regard to global health issues are presented in chapter 5 in order to highlight the importance that they attach to healthcare within the foreign aid agenda. Finally, the conclusions of this study are presented in chapter six.

2. THE LANCET REPORT ON GLOBAL HEALTH: MAIN CONCLUSIONS AND REACTIONS

2.1. Introduction

The report *Global Health 2035: A World Converging within a Generation*, was published in The Lancet on December 3, 2013 (The Lancet Commissions, 2013). The report provides a roadmap to reduce infectious, maternal, and child deaths; to curb Non-Communicable Diseases (NCDs) and injuries; and to achieve pro-poor Universal Health Coverage (UHC). According to the authors of the report, achieving these goals would close the global health gap and save roughly ten million lives a year by 2035 - while simultaneously increasing human productivity and boosting economic growth. The report builds on an earlier health report by The World Bank, the World Development Report (WDR 1993) *Investing in Health* (World Bank,1993). It demonstrated that well-chosen, evidence-based health expenditures are an investment not only in health, but also in economic development. Prompted by the 20th anniversary of *Investing in Health*, an independent commission of 25 economists and global health experts (the Lancet Commission on investing in Health - hereinafter referred to as 'the Commission'), re-examined investment in health. In 'Global Health 2035' the Commission proposed a new investment framework for low-income countries and middle-income countries to achieve dramatic health gains by 2035.

2.2. The challenge

Over the past few decades great progress has been made in the field of (global) health. We all live longer; for example, a girl born today has a life expectancy that is six years longer than a girl born in 1990. However, the world still faces many old and new global health challenges. And this burden is unequally divided in the world; low and middle-income countries are faced with the heaviest burden. These disparities in terms of health are often referred to as global health gaps. For example, a child in Africa is eight times more likely to die before its fifth birthday than a child in Europe. And while there are 3,1 physicians per 1000 people in the Netherlands, there is only 0,04 physician available for the same number of people living in Mozambique (WHO, 2015b). At the same time, diseases that already existed in high-income countries, such as cancer, diabetes, stroke and other NCDs are now also becoming more common among the younger populations (under the age of sixty) in developing countries. Unfortunately, in these countries there are fewer means and services available for the proper treatment of patients. For example, while cervical cancer is largely prevented in western countries due to good detection programmes, it is the most common form of deadly cancer for women in sub-Saharan Africa (CFR, 2014). The incidence of NCDs is rising faster than the decline in infectious diseases, leaving developing and emerging economies with a 'double disease burden'. The global health gap is particularly visible in terms of health expenditures: on average over $947 is spent on the health of citizens in high-income countries; per capita expenditures in low-income countries are a mere $20 on average (Luchetti, 2014) (see also figure 1).

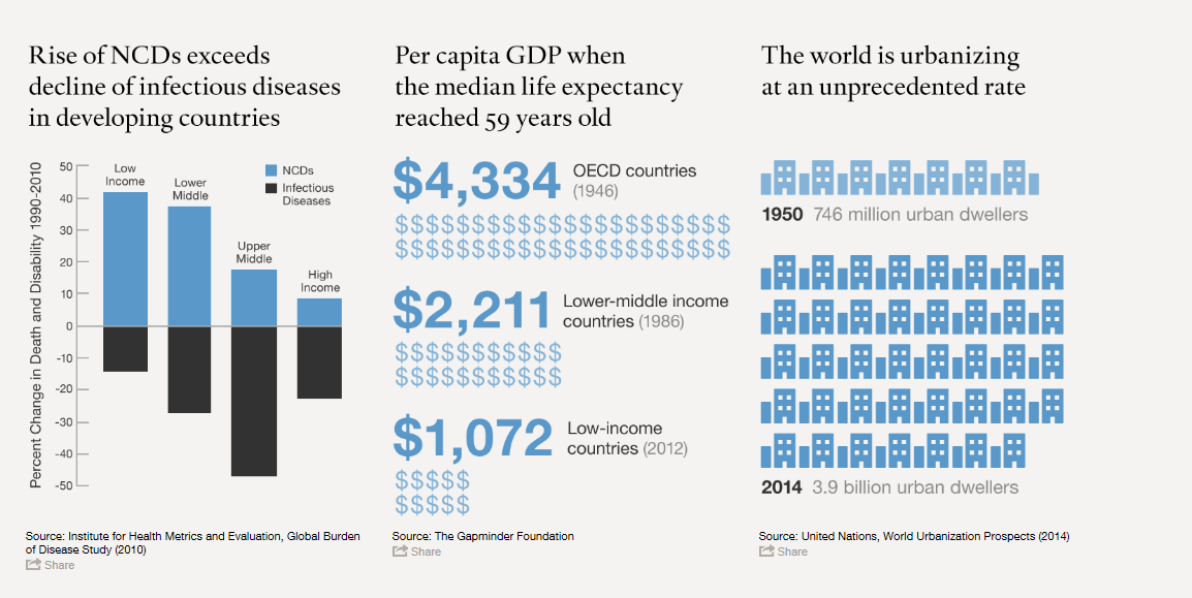

Figure 1: challenges relating to global health (CFR, 2014)

Taking into account the mounting urgency of the described global health challenges and considering that the current international policies on global health (as part the Millennium Development Goals) are ending this year, the publication of 'Global Health 2035' was considered timely. Although progress has been made towards the goals focusing on health issues (Millennium Development Goals 4,5 and 6), a large share of 'unfinished business' remains. Maternal and child mortality is still high in many countries. The report further provides a discussion of the consequences of shifts in global health financing and shifts in the global disease burden. These include economic growth and a growing middle class in emerging economies; diminishing development cooperation budgets from the 'traditional' donor countries; and rising health costs and challenges for households and societies worldwide. The understanding of the global map of disease is changing, as over 70 percent of the world's poor now live in middle-income countries rather than low-income countries. As a result, more than half of the world's child deaths, TB deaths and Aids deaths occur in emerging economies (The Lancet Commissions, 2013). Rapid urbanisation in turn gives rise to other kinds of health hazards compared to the ones inhabitants of rural areas face. With these 'shifts', the global disease burden has also shifted (see figure 2). Based on these developments, the Commission formulated the following guiding question for their report: 'how should low-income and middle-income countries and their development partners target their future investments in health to tackle this complex array of challenges?'

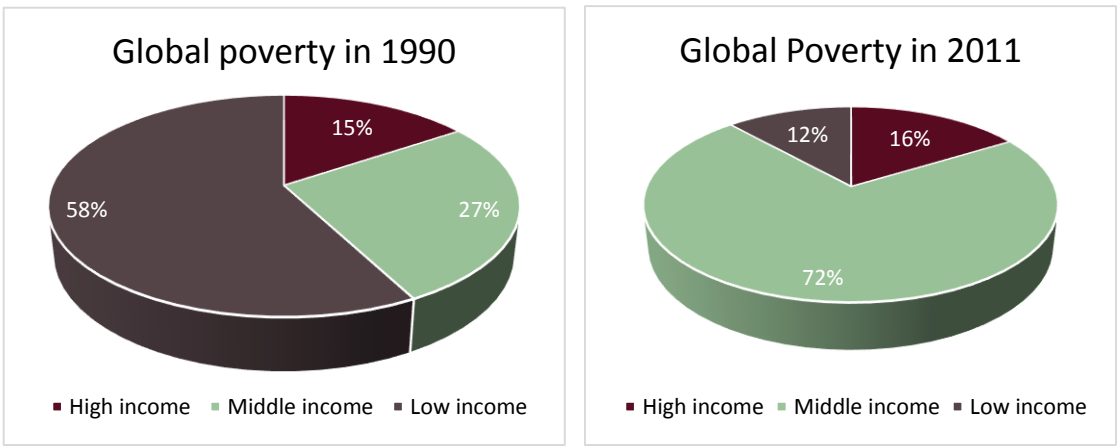

Figure 2. movement of populations from low income to higher income between 1990 and 2011 (The Lancet Commissions, 2013)

2.3. Key messages of the report

The key messages of 'Global Health 2035' are:

a. A 'grand convergence' in health is achievable within our lifetimes, bringing preventable infectious, maternal and child deaths down to universally low levels

According to 'Global Health 2035', our generation has the possibility, both financially and technically, to start closing the global health gap. According to the report, saving ten million lives a year requires about 70 billion dollars per year on investments in health. The report further claims that this cost represents less than one per cent of the additional GDP of developing countries that will be available over the next 20 years due to increased GDP growth in these countries. In other words, an investment by governments of less than one percent of their GDP would avert ten million deaths a year in developing countries. Using the examples of the '4C countries' — Chile, China, Costa Rica and Cuba – 'Global Health 2035' shows that countries can achieve a rapid decline in death rates by investing in health. The 4C countries started off at similar levels of income and mortality as today's low-income countries, but achieved a high level of health care by 2011, largely because health sector interventions had been scaled up. These countries are now among the best-performing middle-income countries, although it should be noted that decreased death rates do not always mean that health statuses are substantially improved. There is still room for improvement in these countries. The Commission lays out a path for today's developing countries to achieve similar rates of progress and to avert about ten million deaths in 2035. With most of the world's poor now residing in middle-incomes countries, these interventions need also to focus on poor sub-populations in emerging economies. The expected economic growth in these countries will easily allow for the use of domestic financial resources to finance investments for the poorest. While low-income countries will require some external assistance, they are expected to be able to finance most of the incremental cost of achieving convergence themselves. Notwithstanding these expectations, development assistance for health (DAH) will still be crucial in achieving convergence, especially for the poorest and most vulnerable countries. The WHO claims that if donor countries would spend 0.1 per cent of their Gross National Income (GNI) on global health, the average per capita expenditures in the poorest countries could rise to $44-60 (instead of the current $20). This is considered the threshold for the provision of basic essential health services to the poorest and would contribute substantially to diminishing the global health gap (WHO, 2001).

b. The returns on investing in health are greater than originally estimated

'Global Health 2035' argued that although the costs of convergence are substantial, at the same time there is an enormous pay-off from investing in health. Instead of using traditional national income accounting (based on Gross Domestic Product), that captures the *'instrumental value'* of better health, 'Global Health 2035' proposed a more comprehensive approach to measuring the returns on investing in health in order to capture the 'intrinsic value' people place on their own improved health.[2] Using the full-income approach to estimate the economic benefits of convergence in developing countries from 2015- 2035, the authors of the report argued that the benefits exceed the costs by a factor of 9-20. By proposing the full-income approach, the Commission hopes to provide finance ministries, donors and other decision-makers with a strong rationale for investing in health, in order to put their countries on a path to rapid improvement in national welfare.

c. Taxes and subsidies are a powerful and underused lever for curbing NCDs and injuries

As described in 'Global Health 2035', low-income and middle-income countries might successfully reduce deaths from infections and maternal and child conditions, but they are also faced with increasing incidences of NCDs and injuries in adults, due to lifestyles changes such as changing food consumption and increased motorised transport. The report proposes steps that these countries could

[2] This is called the 'full income' approach, which combines growth in national income (GDP) with the value people place on increased life expectancy, expressed in the value of their additional life years (VLYs).

take to delay the onset of NCDs and thus reduce premature illness and death. For instance, national governments could curb NCDs and injuries through a combination of population-based measures and highly cost-effective clinical interventions. These include taxation, regulation or legislation and access to information, along with clinical interventions to increase the availability of essential medicines and technologies. The report highlights increasing taxes on tobacco as the single most important intervention along with reducing subsidies on resources such as fossil fuels which produce air pollutants that cause NCDs, to significantly reducing the NCD burden. The report provides the example of China, where a 50 per cent rise in the tobacco price from tax increases is expected to prevent 20 million deaths, while it generates an extra $20 billion annually in the next 50 years. Additional tax revenue would decrease over time, but would still be higher than current levels, even after 50 years.

d. Progressive universalism is an efficient way to achieve health and financial protection

'Global Health 2035' supported two pro-poor pathways to achieving universal health coverage (UHC) within a generation and it encouraged governments to develop a new fiscal system that will help mobilise funds to secure resources for healthcare needs. The first pathway towards UHC involves publicly funded insurance programs that would cover all essential healthcare and public health services. Since these health issues disproportionately affect the poor, impoverished and developing nations would benefit from a transition to 'progressive universalism'. The second pathway provides a larger benefit package funded through a wider range of financing mechanisms, with poor people exempted from all payments. The authors of the report argue that the goal of UHC, if implemented with poor people in mind, could sharply reduce the high levels of poverty by reducing out-of-pocket health spending.

2.4. Important role for the international community

Achieving a 'grand convergence' in global health

The 2035 'grand convergence' goals are summarised as '16-8-4', referring to; reducing under-five child mortality to 16 per 1,000 live births; reducing annual Aids deaths to eight per 100,000 and reducing annual tuberculosis (TB) deaths to four per 100,000. 'Global Health 2035' proposed a detailed investment framework for governments of developing countries to achieve the '16-8-4' convergence goals by:

- Aggressively scaling up new and existing tools to tackle HIV and Aids, TB, malaria, neglected tropical diseases and maternal and child health conditions;
- Strengthening their health systems using a 'diagonal approach'. That is, building systems that specifically improve low and middle-income countries' ability to tackle the highest burden health challenges by creating interventions to improve efficiency and effectiveness throughout the entire health system.

The international community can support governments in developing countries in meeting these targets through the following steps:

- **Finance Global Public Goods (GPGs), particularly research and development (R&D**) Especially for diseases disproportionately affecting developing countries and for managing cross-border externalities such as the flu pandemic. The current global R&D budget on health ($3 billion a year) should be doubled to $6 billion annually by 2020, with half the increment funded by middle-income countries. The report stresses that the core functions of global health, especially the provision of global public goods and management of externalities, have been neglected in the last 20 years and should regain prominence.
- **Provide transitional financing to a select group of countries.** External financial assistance to scale up tools for achieving convergence will continue to be important for some developing

countries. In some cases, middle-income countries will continue to require assistance to eradicate malaria and to combat drug-resistant TB.

- **Tackle antibiotic resistance and support pandemic preparedness.** The development of new pandemic control methods and national and international surveillance and response systems could be supported. Also intellectual property concerns and production capacity for drugs and vaccines could be better addressed.
- **Support capacity building within international institutions**, so that they can transition away from direct country support, towards adequately providing key Global Public Goods. For example, one of the recommendations in the report is that member states fully support the WHO. Furthermore, the Commission advises not only to strengthen the WHO's coordination and leadership roles, but also to refocus its attention on the core activities, particularly strengthening its capacity for technical cooperation with and among countries. Such refocusing would require significant organisational restructuring.

Curbing non-communicable diseases and injuries

To support national governments in curbing NCDs and injuries, 'Global Health 2035' recommended that the international community should:

- **Support population, policy and implementation research** on scaling-up of interventions for NCDs and injuries, including research on how high-income countries can benefit from research in low-income countries through reverse innovation.
- **Provide technical assistance on taxation, trade and subsidy policies** and cooperate to tackle tobacco tax avoidance (through loopholes) and tax evasion (through smuggling and bootlegging).
- **Provide targeted financing** to the poorest countries for the scale-up of selected clinical tools, such as a hepatitis B vaccine (to prevent liver cancer) and an HPV vaccine (to prevent cervical cancer).

Achieving Universal Health Coverage

The report suggests two pro-poor pathways to achieving UHC within a generation and recommends that the international community:

- Supports health systems research, including policy research and implementation research.
- Finances the institutions for revenue mobilisation and pooling of resources, the mechanics of designing and implementing specific pathways for evolution in the benefit package, and the policies for UHC implementation.
- Financing population, policy, and implementation research, e.g. on the mechanics of designing and implementing evolution of the benefits package as the resource envelope for public finance grows.

2.5. How the report was received internationally

'Global Health 2035' was developed by a renowned group of experts and it covers a broad range of challenges and policy options. To what extent did the report receive international attention? The report was launched globally on December 3, 2013. At events in London, San Francisco, Johannesburg and Berlin, key findings of the report were presented and discussed with a broad range of stakeholders, who re-examined the case for investing in health and called for international collective action. The Commission has also been invited to discuss the report's findings within the UN, at the World Bank, the International Monetary Fund (IMF) and at events such as the World Economic Forum in Davos. Through opinion articles and editorials in newspapers and online media, the messages of the Commission were popularised and widely disseminated and discussed. Hence, the launch of 'Global health 2035' was met with widespread international news coverage, in print media, TV, online and

radio[3]. Most news stories focused on the report's investment plan for achieving a ‘grand convergence’, like a reduction in avertable infectious, maternal, and child deaths to universally low levels by 2035. Even recently, more than a year after the report was first published, Dr. Gavin Yamey of the Commission spoke about achieving a grand convergence in women's health by 2035 during the Inaugural World Women's Health and Development Forum (February, 2015). This elucidates the continuing resonance of the report and its content.

The Commission acted as a technical resource to various countries who were seeking to plan for future national aid programmes, as well as domestic health policies. In Sweden for instance, the report led to a review by the Swedish Expert Group for Aid Studies (Yamey et al., 2014) of Swedish health aid. And to the proposition of policy options that could enable Sweden to align its health aid with emerging needs and priorities. Similarly, India used the report as an incentive to develop a specific brief on the returns on investing in health in India. This brief outlines the necessary tools and financing investments for India to achieve convergence, and the economic and health returns on these investments (Global Health 2035, 2014).

The report has led to some reactions from academics. Yates & Dhillon (2014), for example, expressed their satisfaction with the report by stating that “universal coverage can only be accomplished through public financing systems in which the state plays a leading part in raising revenues, pooling funds, and purchasing services.” Chiriboga et al. (2014), on the other hand, expressed their concern and called the report “a re-run of the 1993 World Development Report, whose policies contributed to the shrinkage of government institutions and massive privatisation and fragmentation of health-care systems, effectively decreasing coverage and accessibility.” They also argued that the recommendations are based on the principle of return on investment, not on health equity, which creates a double standard: one for the rich and another for the rest of us. The latter seems to be somewhat contradictory, as the report presents recommendations aimed at increasing health equity, while presenting economic gain as an extra benefit of investing in global health. It should be noted there are several other key publications on global health in which subjects like equity, human rights and governance are central.

In conclusion, ‘Global Health 2035’ has received a fair amount of attention in the international arena, and it was viewed by some countries as a source of inspiration to develop national policies or development cooperation policies in the field of health. The report distinguishes itself from many other studies on global health in the sense that it focuses on the broad spectrum of health issues (from infectious diseases to NCDs) and that it translates health gains into economic value. The next chapter focuses on current policies in the field of global health in the Netherlands. Chapter four presents and analyses the views of health experts on ‘Global Health 2035’ as well as global health issues in the Netherlands.

[3] See for example http://globalhealthsciences.ucsf.edu/news-events/global-health-2035-in-the-news

3. CURRENT NATIONAL POLICIES ON GLOBAL HEALTH IN THE NETHERLANDS

3.1. Introduction

Like many other donors, the Netherlands spends part of its development cooperation budget on improving healthcare services in developing countries. Globally, government aid spending on health grew from $5,7 billion in 1990 to $27 billion in 2012 (Tielens, 2013a). As described in chapter one and two, a multitude of global factors are placing public health and health systems worldwide under pressure; the global interdependencies and shared responsibilities in the field of health are more apparent than ever and new policy approaches are needed. To what extent is this acknowledged in the Dutch global health policies? The Dutch government recognises the need to take an international approach to finding solutions to global challenges, as illustrated in the policy note 'A New Agenda for Aid, Trade and Investment.' It states:

> "The Netherlands wants to move forward in the world, and move forward with the world. We are involved in global problems. Ours is one of the most open countries in the world. We depend on other nations' development for our own wellbeing and prosperity. Sustainable, inclusive growth is in our own interests and in the interests of others." (Ministry of Foreign Affairs, 2013a: 5)

It is, however, not explicitly stated that this view includes a global perspective on health. At the moment some global health issues are part of the aid policies of the Ministry of Foreign Affairs, whereas other topics (such as the Dutch role vis-à-vis the WHO) fall under the Ministry of Health, Welfare and Sports. As a result, a coherent view on global health is lacking and the topic seems to be falling a bit between two stools. This is, amongst others, reflected in the lack of a government-wide strategy on global health. Many other European countries, such as Norway, the United Kingdom, Germany and Sweden do have such an overarching strategy.

This chapter discusses national policies on global health in the Netherlands. The chapter particularly focuses on development cooperation policies and provides a short overview of the evolution in Dutch thinking and policies regarding (global) health and development cooperation since the 1950s. It analyses the current Dutch policies related to global health issues, also in relation to those of other European donors. Furthermore it touches upon Dutch domestic health policies and spending in order to provide a perspective on global health policies.

3.2. Global health embedded in Dutch policymaking

Although there is a separate Minister of Foreign Aid and Development Cooperation, Dutch development cooperation is incorporated within the Ministry of Foreign Affairs. The Dutch focus in the field of global health is currently mainly on Sexual and Reproductive Health and Rights (SRHR) policies, formulated by the Ministry of Foreign Affairs (see also Steurs, Van de Pas & Van Belle, 2015). SRHR is one of the four Dutch development cooperation priorities; other priorities are water, food security and peace and security.

Notwithstanding the absence of a coherent shared health policy, it should be noted that in some health-related cases the Ministry of Foreign Affairs does collaborate closely with other Dutch ministries. For example with the Ministry of Economic Affairs, Agriculture and Innovation to fund the Top Sector Life Science and Health (one of the industries prioritised by the government, in which

activities targeting sexual health are given priority funding.[4]) There is also a partnership between the Ministry of Foreign Affairs, the Ministry of Health, Welfare and Sports and the World Health Organization (WHO) which the Ministry of Health leads. In 2014, the Health Ministry started a new partnership programme (2014-2017) with the WHO focusing on antimicrobial resistance, as well as cross-border health threats, safety of vaccines, and medical devices and effective health systems. The programme has a budget of € 15.9 million. The Ministry of Health also works together with the Ministry of Economic Affairs on issues such as antimicrobial resistance and life sciences and health. To illustrate, the Dutch government, in response to a request by the WHO, hosted a Ministerial Conference on Antimicrobial Resistance mid-2014, to accelerate political commitment and global action to respond to this international health threat. The conference was organised by the Dutch Ministers Schippers (Health, Welfare & Sports) and Dijksma (Agriculture). As Box 2 shows, inter-ministerial collaboration also takes place around health emergencies.

Box 2. Emergency assistance on Global Health

The Netherlands takes action and works in close partnership with other countries and international organisations when health emergencies happen. For example, the Ebola outbreak occurred in West Africa, but turned out to be a threat for the Netherlands as well.

The Ministry of Foreign Affairs, the Ministry of Health, Welfare and Sports, and the Ministry of Defence worked together to arrange emergency assistance such as medical devices, protective clothing, as well as informing Dutch citizens about the disease, and controlling the risk of contamination in the Netherlands (Rijksoverheid, 2015b).

In January this year, at the World Economic Forum in Davos, Minister Lilianne Ploumen (Ministry of Foreign Affairs) and Minister Edith Schippers (Ministry of Health, Welfare and Sports) called for rapid medical response teams that could be used to deal with acute health crises around the world, like the current Ebola epidemic. Already in 2009, following the Mexican flu epidemic, an international committee concluded that the world was not adequately prepared for a pandemic and recommended establishing a Global Health Emergency Workforce. The two ministers are now calling for such a Workforce, to be coordinated by the WHO (Ministry of Foreign Affairs, 2015)

3.3. Short overview of the history of Dutch development assistance

Dutch development cooperation formally started in 1949 in reaction to the *'Point Four'* programme designed by President Truman in the United States. Initially, the Dutch efforts focussed on sending experts to developing countries through the UN. In addition to moral and idealistic motives to fight poverty, from the beginning enlightened self-interest has been an essential part of Dutch aid policies. Aid was also important to promote Dutch corporate interests and Dutch scientific knowledge, to enhance Dutch international prestige, to maintain Dutch international influence, and to create employment for former Dutch colonial experts (Spitz, Muskens and Van Ewijk, 2013). In addition to spending aid through bilateral and multilateral channels, the Dutch also started a co-financing system for Dutch development NGOs in the 1960s. Within this system, a large part of the Dutch development budget was allocated with Dutch development organisations who spent part of this funding on health projects.

[4] The Dutch government has chosen nine knowledge-intensive and export-oriented 'top sectors', which are supported to optimise their contribution to the Dutch economy and to solving global issues. Besides Life Sciences and Health (LSH) other Top Sectors include water, agro & food, chemicals, creative industry, energy, high tech systems & materials, logistics and horticulture and propagating stock (http://topsectoren.nl/english).

Although moral motives and self-interest have always informed Dutch development aid, health was for a long time not seen as something that could also benefit the Dutch. Health spending was mostly viewed from the perspective of social development; it was based on the idea that investing in social issues such as healthcare and education would lead to economic development in developing countries. Over the last five years, the Dutch development discourse gradually shifted to an economic discourse, based on the premise that stimulating economic development will lead to social development, e.g. setting up healthcare systems.

3.4. Current Dutch development policy

In 2010, the Dutch Scientific Council for Government Policies (WRR), one of the main independent government advisory bodies in the Netherlands, advocated a thorough change of Dutch development policies. The Council encouraged a stronger thematic focus, an emphasis on fewer countries, an alignment of development priorities with Dutch expertise and interests, and a shift from social to economic development. Ben Knapen, the former State-Secretary for Development Cooperation, followed the WRR's advice and made far-reaching changes to the Dutch aid policy. Since end of 2012, when the VVD (liberal) and PvdA (labour) coalition government was elected and Lilianne Ploumen was appointed 'Minister for Foreign Trade and Development Cooperation', the government has sought to reduce and refocus Dutch development assistance in the following manner:

a. Reduce Official Development Assistance (ODA) by €1 billion between 2014 and 2017.
b. Increase alignment of development aid with foreign trade, through a stronger role of the Dutch private sector.
c. Maintain four thematic priorities and further concentrate funding for these sectors.
d. Reduce funding for cross-cutting themes: good governance, environment and education.
e. Have three kinds of bilateral relations with 15 partner countries: aid, transition, and trade relations (Ministry of Foreign Affairs, 2013a).

3.4.1. Reducing Official Development Assistance (ODA) and spending on global health

In 2011, for the first time since 1975, the Dutch financial commitment to development cooperation has fallen below the internationally agreed target of 0.7 per cent of Gross National Income (GNI). This is a critical development, from an international perspective. While other donor countries are still striving to achieve the target, the Netherlands has in the past surpassed it, but it has now reduced its financial commitment to ODA. While Dutch aid in the field of (global) health has gradually decreased in absolute terms since 2008, the share of ODA allocated to health has remained constant at around 9-10 per cent of the Dutch ODA budget. In 2012, health ODA accounted for $532 million (€414 million) or nine per cent of the total ODA. In comparison, in 2012 the Dutch government spent €83,4 billion on domestic health; which represents 21 per cent of the total government budget (RIVM, 2014). The Netherlands has one of the highest expenditure rates on domestic health in the world (right after France and the United States) and has been struggling to control the continuous increase in health expenditures (RIVM, 2014). In other words, the Dutch spending on global health as part of development cooperation is less than 0,1 per cent of the Dutch GNI and less than 0,5% of the Dutch government spending on domestic health. Box 3 provides more information about the Dutch domestic health priorities in relation to the key messages of 'Global Health 2035'.

Box 3: Dutch domestic policies in relation to 'Global health 2035'

'Global Health 2035' emphasised the importance of taxes and subsidies to curb the incidence of NCDs and injuries, as well as the importance of UHC. Compared to many other countries, the Netherlands has achieved quite a high level of health equity. Nevertheless, the incidence of health problems is still not equally divided amongst all groups in Dutch society. Dutch citizens with a low social economic status are usually less healthy than their fellow citizens, who have a higher social economic status. In fact, their healthy life expectancy on average is six years or less. The Netherlands has adopted strategies to decrease this health gap by 25 per cent in 2020, a target that the National Institute for Public Health and Expenditure (RIVM) is monitoring. The Netherlands has longstanding experience in preventing NCDs. Taxing tobacco and alcohol is one of the methods in the fight against NCDs. UHC has been put into practice in so far as a basic health insurance is mandatory for all Dutch citizens. However, this insurance is not free-of-charge, there are approximately 340.000 people in The Netherlands who have not paid their insurance during six months or longer (Rijksoverheid, 2014b).

The Netherlands allocates around half the funding available for SRHR via multilateral organisations. The Global Fund, UNFPA, UNAIDS, GAVI and the WHO are the main recipients. UNICEF, UNWOMEN and the World Bank also use Dutch funding on SRHR issues. These recipients were selected with the idea in mind that these organisations and funds can achieve much more than bilateral donors, due to their specific mandate, expertise, and greater reach (Ministry of Foreign Affairs, 2012). Though the Netherlands has been an active partner in healthcare sectors in Bangladesh, Yemen, Ethiopia, Mozambique, Mali, and Ghana for some time, bilateral health ODA decreased over the past years.

3.4.2. Increased focus on trade through a stronger role of the Dutch private sector

The shift towards economic development, effectiveness, and self-interest with an increased focus on the role of the Dutch private sector in development programmes, is reflected in Minister Ploumen's new agenda for aid, trade, and investment. This agenda embraces three ambitions: to eradicate extreme poverty ('getting to zero') in a single generation; sustainable and inclusive growth all over the world; and Dutch enterprises achieving success abroad. As such, the Netherlands aims to contribute to a more coherent and sustainable agenda for aid and trade. An example of this new focus is the Dutch Good Growth Fund (DGGF) which provides export and investment financing to Dutch and local businesses for activities in developing countries that should contribute to local economic development.

The shift in focus is connected to a wider international debate about the 'value' of development aid. The debate is premised on the assumption that private sector engagement will provide greater impact of donor money for some leading donor countries, such as the Nordic countries and the United Kingdom. However, not all countries are as straightforward as the Dutch Ministry of Foreign Affairs stating: "today more than ever, the Netherlands' foreign policy is putting Dutch interests first" (Ministry of Foreign Affairs, 2011a).

3.4.3. Focus within Sexual and Reproductive Health and Rights

SRHR (incl. women's rights and HIV and Aids) is the only thematic priority that is not affected by recent budget cuts. This exemplifies the importance that is awarded to this issue in general development policies (Rijksoverheid, 2014a). The focus on SRHR finds it origin in Dutch culture and history. Since the 1960s, the Netherlands has been very progressive when it comes to sexual health

and rights; in particular as advocates of the rights of lesbians, gays, bisexuals, and transgenders (LGBT), concerning gender equality and when it comes to self-determination in sexual matters, e.g. birth control (Spitz, Muskens & van Ewijk, 2013). The international stance of the Netherlands reflects its domestic policies. The Dutch relative abortion rate is one of the lowest in the world and the use of contraceptives is widely accepted. Both maternal healthcare and birth control are widely available and mostly covered under the national health insurance scheme (Ministry of Foreign Affairs, 2011b).

The Dutch policy in the field of SRHR is mainly characterised by a focus on advocacy and, to a lesser extent, on improving the way SRHR-related healthcare is organised. In order to reduce maternal mortality and ensure access to reproductive health (MDG5) globally, the Dutch government has identified the following objectives (Ministry of Foreign Affairs, 2012):

- Improving access to effective contraception, medicines, vaccines, and reproductive health supplies.
- Teaching young people about sexuality, so they can make their own choices about relationships, sex, and the use of contraception.
- Improving the quality of and access to public and private health services, in relation to SRHR.
- Removing impediments to healthcare for marginalised groups - also referred to as 'key populations', such as drug users, prostitutes, homosexuals, and prisoners, in various countries.

According to a policy evaluation (Ministry of Foreign Affairs, Policy and Operations Evaluation Department, 2013), Dutch policy on SRHR is consistent and the Netherlands has successfully defended to adopt a shared language on SRHR in international forums. The Netherlands particularly emphasises the more 'sensitive' issues, such as the protection of the rights of young people and key populations. However, the evaluation also points out that inequalities between rich and poor people have hardly been reduced and that inequities between poor and rich regions within a country persist. In addition, Dutch efforts have contributed insufficiently to the implementation of interventions regarding some policy priorities, particularly the prevention of unsafe abortion, the promotion of sexual health, and access to SRHR for key populations. The evaluation further warns that the current shift away from strengthening health systems - an essential condition for achieving the Dutch policy objectives - especially the reduction of maternal mortality - is creating a gap that needs to be addressed.

In other words, the Dutch policy on SRHR has contributed to better knowledge about sexual rights and health and improved access to SRHR services and commodities, but Dutch efforts were less effective in promoting SRHR for key populations and strengthening health systems, which reveals a gap between Dutch policies and practice.

3.5. Examples of the focus on disease-control in relation to Dutch SRHR policy

Although the Dutch government's focus on health centers around SRHR, it also includes vaccinations and research and development. For example, Minister Ploumen has made access to vaccinations against preventable infectious diseases such as tetanus, diphtheria, measles, rubella, polio, hepatitis B, pneumococcal, diarrhoea caused by rotavirus, and the introduction of new vaccinations such as the HPV vaccine, a main focus in her SRHR policy (Ministry of Foreign Affairs, 2014c). Also, in five of the eight Dutch SRHR partner countries (Benin, Burundi, Ghana, Mali and Mozambique), pilot projects started and HPV vaccination is expected to become part of a wide SRHR-programme for adolescents and young people. Minister Ploumen is committed to ensuring that embassies in all eight SRHR partner countries start a dialogue with the government on the HPV vaccine, in close collaboration with the WHO and UNICEF.

The Netherlands is also a strong supporter of health-related research and development, providing almost €70 million (US$97 million) in 2011-2014 through the 'PDP Fund against poverty-related diseases'. It total, seven PDPs are supported in order to stimulate the development of medicines, vaccines, diagnostics, and other instruments to tackle poverty-related diseases, increase access to these products, and contribute to research capacity development in developing countries. In 2014, this programme has been evaluated and a new phase of the PDPs will commence in 2015, based on the positive outcome of the evaluation (Ministry of Foreign Affairs, 2014a). In addition, the Ministry of Foreign Affairs has launched a Knowledge Platform for SRHR: Share-net International, to strengthen the knowledge-base of the government's SRHR policy. This platform plays a central role in identifying and articulating knowledge demands, formulating research questions, and promoting knowledge exchange.

Furthermore, the government has made new funding available in support of SRHR, including;

- In September 2014, the government launched the 'Amplify Change Fund' (Dutch contribution: €5 million for 2015-16) in partnership with Denmark, and, amongst others, the William and Flora Hewlett Foundation, as welll as the David and Lucille Packard Foundation, to support NGOs in South Asia and Sub-Saharan African who engage in advocacy in the SRHR field. The fund aims to empower young people, men and women to realise their sexual and reproductive rights. It also supports NGOs that operate in countries where the needs are greatest.
- The government will launch a new grant framework for SRHR in 2016 that will focus on all four priority areas of the Dutch SRHR policy (young people, resources, services, and rights) with special attention for those themes where the Netherlands can add value. This includes more controversial topics, such as key populations, abortion, and comprehensive sexual education.
- A new strategic partnerships grant framework for lobby and advocacy (called 'Dialogue and Dissent') has been set up and will run from 2016-2020. The government has selected various partners working on SRHR, including a consortium consisting of Dutch NGOs WEMOS, Amref flying doctors, Health Action International, and the African Centre for Global Health and Social Transformation (ACHEST) to look at strengthening health systems in order to achieve the SRHR targets.
- The Netherlands recently stepped up its support to the Global Fund to Fight Aids, Tuberculosis and Malaria by pledging €185 million ($251 million) for 2014-2016 (compared to €163.5 million or $227 million for 2011-2013), as it considers the Global Fund a key instrument to promote SRHR. In addition, it is one of the original GAVI donors and has recently increased its support from €200 million to €250 million for 2016-2020.

Despite global health somewhat falling between two stools as a policy field, several efforts are made to improve global health. These efforts are mostly carried out through the Ministry of Foreign Affairs and funded from the development aid budget. In terms of domestic policy, the Netherlands places great emphasis on health, as it spends one-fifth of the government expenditures on domestic health. Despite the domestic policies being in line with the 'Global Health 2035' recommendations on UHC and health equity, there is a discrepancy between the attention for domestic health and that for global health. In that sense, there is little acknowledgement of the urgent global health challenges that the world faces and the vulnerability of the Netherlands as an open economy.

4. ANALYSIS OF ADDRESSING GLOBAL HEALTH IN THE NETHERLANDS

The previous chapter addressed the fact that Dutch policies in the field of global health mainly approach SRHR as one of the four priority areas of development policies and that a global health strategy is currently lacking. This chapter discusses the views of Dutch global health experts on the impact of 'Global Health 2035' and its implications for Dutch policymaking. It also discusses the experts' views on the extent to which global health is on the Dutch policy agenda. In total, 18 global health experts, were interviewed, including academics, politicians, policymakers (both connected to the Ministry of Foreign Affairs and the Ministry of Health, Welfare and Sports), representatives of NGOs and the private sector. The semi-structured interviews were conducted in January, February, and March 2015. This chapter also draws on relevant literature, to provide context to the findings.

4.1. Views on the Lancet Report 'Global Health 2035' and its impact in the Netherlands

The report 'Global Health 2035' was generally well-known and it was praised for being timely as it was published just before the transition from the MDGs to the SDGs. Few people, however, had actually read (part of) the report. 'Global Health 2035' was viewed as one of the influential reports, rather than the most influential document. Other articles and reports of The Lancet focusing on specific health issues and reports from other institutions like the European Commission were also considered important. It should also be noted that an economic focus is central in 'Global Health 2035', while there are other landmark reports focusing more on health equity, human rights, or governance issues related to health (for instance. WHO & Commission on Social Determents of Health 2008; Kickbush & Gleicher 2012 and publications of The Lancet - University of Oslo Commission on Global Governance for Health).

Generally, 'Global Health 2035' was commended for its emphasis on the importance of investing in health in economic terms, although it was argued that the World Bank report published in 1993 already did the same. Some interviewees warned that one should be careful not to measure the value of health in economic terms only, as health has an inherent value and attention should also be paid to the human aspects of health. The positive approach of the report revolving around the central idea that 'a grand convergence can be achieved, provided enough money is spent' was welcomed by some, while others criticised it for being too simplistic and optimistic. This view is related to the limited consideration in the report of a right-based approach and the lack of a focus on inequality and inclusive development. Although much progress has been made in poverty alleviation worldwide, it is argued that inequality has increased and there is still a large group of poor people who are not being reached. Inclusiveness is indeed seen as one of the main challenges in the international debate (see for instance United Nation 2014; United Nations General Assembly 2014), as well as in the current development cooperation debate in the Netherlands (see the consultation 'Promoting Inclusiveness in the Dutch Policy Agenda on Trade and International Cooperation' that took place in March 2015[5]).

The emphasis on UHC as put forward in 'Global Health 2035' was widely embraced. Especially in relation to the importance of Health Systems Strengthening (HSS) to improve global health and to control diseases. Related to this, a majority of respondents mentioned the relative lack of attention for health systems in the Dutch development aid policy. Consideration for the emerging NCDs was generally also supported, because chronic illnesses were viewed as one of the most imminent health challenges worldwide. Lastly, the high child and mortality rates that are highlighted in the report were

[5] http://includeplatform.net/consultation-main/opportunities-inclusiveness-trade-international-development/

mentioned as a rationale for focusing Dutch policies on SRHR, especially considering the considerable proportion of young people in the demographics of many developing countries.
The report's strong emphasis on investing in research and development (R&D) was critically received, as experts felt that more attention should be awarded to the implementation of practices (see also elsewhere in this chapter). Although 'Global Health 2035' provided several recommendations, it was also criticised for not being closely aligned to the social reality on the ground.

While this research focuses mainly on the role of the Netherlands in relation to international cooperation, the usefulness of 'Global Health 2035' for the Netherlands itself was also discussed. For instance, it was suggested that the Netherlands can learn from developing countries, because the Dutch struggle to keep healthcare affordable. Especially emerging economies have knowledge of and experience in providing low-cost solutions, without compromising the quality of care. 'Global Health 2035' also addressed this as an opportunity for an exchange of ideas. It was noted that there is a discrepancy between the domestic health policy and the Dutch global health policy. Health systems are an important topic in national policy making (including the mandatory basic health insurance for all Dutch citizens), both in terms of budget and in terms of the public debate. However, global health is hardly addressed in development cooperation.

'Global Health 2035' does not seem to have had an impact on Dutch policy. For instance, key policy documents made no reference to the report and no questions were asked in Parliament. The report was also not discussed within the Top Sector Life Science and Health (LSH). Some interviewees, including scientists, policy makers, and NGO representatives were sceptical about the impact of reports in general, they claimed that only important and transnational events, such as the Ebola outbreak, will really trigger the discussion on and attention for global health. An example of this at the European level is the rather unique political calls for more research on Ebola; in July 2014 the European Commission for instance decided to spend €24,4 million to accelerate Ebola research (Brady, 2014).

In conclusion, 'Global Health 2035' received quite some attention in the international arena. Some countries considered it a source of inspiration to develop national policies or development cooperation policies in the field of health. However, in the Netherlands the report was not clearly flagged as an important document. up It was considered one of many important reports, instead of the most influential report.

4.2. Global health as part of Dutch policy

Nearly all interviewees agreed that there is limited attention for global health and that there is no global health strategy in the Netherlands (this has been also discussed before, see for instance Tielens 2013a; Tielens 2013b; Tijtsma, 2013; Wemos 2013). More attention should be awarded to global interlinkages and interdependence in the field of global health. This could be achieved by, for instance, drawing up a joint global health strategy at Government level. The benefit of having a shared global health strategy could be that various ministries – depending on the topic - would be forced to work more closely together. With an agreed global health strategy in place, global health strategies would also be more firmly established and less prone to political shifts. According to most interviewees global health is generally not on the agenda of the Minister for Health, Welfare and Sports. It was argued that the ministry's policy is mainly based on what is beneficial to Dutch domestic health priorities, which is also in line with its mandate. At the same time, the Minister for Foreign Trade and Development Cooperation is has generated a particular focus on SRHR in the field of health, with little attention for other issues of global concern. The global health issues that are not of immediate national concern and the issues that do not fall under SRHR, fall in between the policy focus of the Ministry of Health, Welfare and Sports and the Ministry of Foreign Affairs. Antimicrobial resistance forms an

exception to this rule and it was mentioned as the only global health issue that is on the radar of the Minister of Health, Welfare and Sports. Antimicrobial resistance was typically seen as an issue that requires a global governance approach, which should be shared by the Ministries of Foreign Affairs and Health, Welfare and Sports, as well as the Ministry of Agriculture. According to the WHO, antimicrobial resistance is indeed an increasingly serious threat to global health that requires action across all government sectors and society (see Box 6 below for more information). According to some interviewees, collaboration also takes place between the ministries on health-related trade missions. It was, however, hard to find documentation that could corroborate this collaboration.

It was also argued that the Netherlands has much to offer in the field of global health issues, both in terms of providing expertise and in economic terms. Specifically, the Dutch approach to curbing NCDs, establishing broader healthcare arrangements (the organisation of care), and the health insurance system, were mentioned as international assets. The experts felt it was a missed opportunity that in this respect the Netherlands barely makes use of its economic potential. This is striking, because the Dutch government aims to connect aid and trade. More broadly, health was not only identified as a prerequisite for economic development, but also vice versa. The willingness of foreign companies to enter local markets is dependent on the existence of well-functioning health systems, as they want to ensure access to adequate healthcare for their expat employees.

4.2.1. Policy coherence on (global) health issues

The lack of consideration for global health issues is reflected in the limited the budget and resources allocated for the issue; currently a handful of people in the Netherlands focus on global health within both ministries (Health and Foreign Affairs). The interviewed health experts argued that more attention should be paid to global health issues, taking into account both the economic potential of the Dutch health sector, as well as the vulnerability of the Netherlands as a trade hub. The Ministry of Foreign Affairs and the Ministry of Health, Welfare and Sports should both dedicate more staff and resources to global health issues and collaborate more closely on these issues. Most interviewees felt the Ministries of Foreign Affairs and Health, Welfare and Sports operated quite independently from each other, except during the Ebola outbreak. At that time, the Ministry of Defence was also represented in a consortium to both deal with the health situation in West Africa and with transnational linkages to the Netherlands. There was less clarity on whether exerts felt global health should be embedded mainly within the Ministry of Foreign Affairs, Health, Welfare and Sports, or both. It was also suggested that in order to achieve a really coherent global health strategy, the Ministries of Social Affairs, Finance, and Economic Affairs should be involved. One expert suggested having interdepartmental taskforces on specific global health topics with budgets attached to them. In relation to this, it was argued that health is still being viewed too much in isolation, instead of in relation to other themes, such as education, urban planning, migration and housing. This was also a main critique of a group of 40 scientists assessing the proposed SDGs (ICSU & ISSC 2015). Countries such as the United Kingdom and Sweden could serve as an example, as they have clearly specified in their global health strategies how the responsibilities are divided up among ministries and national agencies.

Box 4. Examples of global health strategies in other European countries

Several interviewees referred to European countries that already have global health strategies, such as Norway, Sweden, Switzerland, and the United Kingdom. These could serve as example for the Netherlands. To illustrate, the United Kingdom was the first nation to publish a cross-Government strategy for global health, in September 2008, which aimed to set out how Government departments should work together coherently to improve health in the United Kingdom and overseas (HM Government, 2011; Public Health

England, 2014). Sweden was the first country to appoint a Global Health Ambassador in 2012, underscoring the country's desire to raise its profile in the area of health and increase its efforts in achieving the MDGs in the run-up to 2015. The country's strategy forms the basis of Sweden's cooperation with the WHO during the period 2011-2015 (Swedish Ministry of Health and Social Affairs, 2011). Likewise, Norway's white paper on global health establishes clear priorities for a coherent Norwegian policy on global health in 2020. Norway's strategy focuses, among others, on NCDs, including lifestyle diseases, as the country recognises that these diseases entail challenges that are different to communicable and poverty-related diseases. NCDs are connected to economic interests and the marketing of harmful products such as tobacco, alcohol and unhealthy food. Norway views health as a global public good, transcending both geographical boundaries as well as different themes: 'Health issues are deeply woven into the social fabric of all countries, and often cut across sectors. Health is therefore of great political importance.' (Norwegian Ministry of Foreign Affairs, 2011:8). For more information on global health policy see also; Brown, Yamey Wamala (2014).

4.2.2. Support for policy priority Sexual and Reproductive Health and Rights

Interviewees generally supported the Dutch development cooperation focus on SRHR, because of its perceived unique added value in this field. However, this focus comes at a cost; there was concern that SRHR as a policy priority is currently operationalised in a narrow manner which implies that there has been less attention and funding for other (global) health issues. Furthermore, various respondents considered the strengthening of health systems a prerequisite for delivering on SRHR. They emphasised the need for the alignment with national health service delivery systems and investing in Health System Strengthening (HSS).

Box 5. Antimicrobial resistance: a global concern

According to the WHO's 2014 report on global surveillance of antimicrobial resistance, antimicrobial resistance is no longer a prediction for the future; it is happening right now, across the world. It is threatening the ability to treat common infections in the community and local hospitals (WHO, 2014). Without urgent, coordinated action, common infections and minor injuries, which have been treatable for decades, can no longer be treated and might even lead to fatalities. Antimicrobial resistance hampers the control of infectious diseases, as it reduces the effectiveness of treatment, which means patients remain infectious for a longer time. Antimicrobial resistance also increases the costs of healthcare; when infections become resistant to first-line drugs, more expensive therapies must be used. A longer duration of illness and treatment also increases the economic burden on families. Furthermore, without effective antimicrobials for the prevention and treatment of infections, the success of organ transplantation, cancer chemotherapy, and major surgery would also be jeopardised. Finally, antimicrobial resistance can potentially threaten health security and damage trade and economies. The growth of global trade and travel allows resistant microorganisms to be spread rapidly to distant countries and continents through humans and food. The WHO urges policymakers, scientists and the industry to help tackle resistance by fostering innovation and research and the development of new vaccines, diagnostics, infection treatment and other tools.

4.2.3. Impact of the Ebola outbreak

Whereas the Ebola outbreak was widely discussed and referred to as ‘a wake-up call’ to address global health in the Netherlands. Ebola helped, as one interviewee put it, to place the ‘abstract’ topic of global health on the agenda. It created a sense of urgency and revealed the weaknesses in the global health system, as has also been pointed out in the Lancet (O'Hare, 2015). It exemplified how a disease occurring in one part of the world could easily travel to other continents. The Ebola outbreak was even referred to as ‘timely’ and one interviewee added that if it had led to victims in the Netherlands it would have gained much more attention.

During the Ebola outbreak, different ministries in the Netherlands collaborated to coordinate the support to the affected areas and to prevent the spread of the disease to the Netherlands via transnational movements of people. The provision of emergency assistance in collaboration with NGOs, was mentioned as something that functioned quite well, as well as taking measures to effectively control the disease and treat people who were possibly affected and were traveling to the Netherlands. However, there was also concern that Ebola was more or less a ‘hype’ and that the attention for communicable diseases was likely to be short-term. As one respondent argued, global health is not really a political issue; it is not a controversial topic and therefore it easily slips off the political agenda.

Several respondents also argued that the Ebola crisis made it painfully clear that the WHO needs strengthening and restructuring (see also Horton, 2015; Van Schaik & van de Pas, 2014). At the international level, the Ebola outbreak has led to a special Ebola session at the WHO, where a resolution with more structural reform aspects was adopted. The resolution contained concrete action plans and a special contingency plan for emergencies.

Because of the Ebola outbreak, more EU research funding for Ebola was made available, which meant there were fewer funding opportunities for research of other diseases, such as research on medical treatment of malaria. As a result, other global health issues which are a bigger threat than Ebola, have received less attention. Antimicrobial resistance for instance, was considered a much larger threat to global health than Ebola, according to the interviewees. One expert expressed relief that the Ebola outbreak has not led to a policy shift away from SRHR issues, although Ebola is also related to SRHR, as the Ebola outbreak has affected women and girls disproportionally (see also Menéndez et al, 2015).

Box 6. Global Public Good as a framework for global health issues?

The term Global Public Goods (GPGs) is sometimes used in literature focusing on global health, but there is no agreed definition or shared view on what aspects of global health are GPGs. GPGs can be defined as cross-border issues, which are of common interest to people worldwide and no one should be excluded from their potential benefits (Kaul, Grunberg & Stern 1999; AIV 2013; van Ewijk, 2014). The Lancet Commission on investing in Health uses the concept of GPGs especially to refer to the political and technical leadership and advocacy, learning from experience and facilitating of the transfer of knowledge on global health issues. According to most interviewees, global health in itself can also be considered a GPG, while others argued at least specific parts of global health are GPGs; e.g. antimicrobial resistance and infectious diseases. The phrase ”TB anywhere is TB everywhere” (a central theme at World TB Day on 24th March 2007*) was mentioned to illustrate that infectious diseases can be regarded as GPGs. At one point infectious

diseases were discussed as one of the GPGs the Netherlands could focus on. However, it disappeared from the policy agenda, likely because there was no support within the Ministry of Foreign Affairs. The concept of GPG was also considered too abstract and theoretical to effectively address global health issues. Nearly all interviewees felt more attention should be paid to global health, whether or not a GPG framework was used was less important.

*UNAIDS website http://www.unaids.org/en/resources/presscentre/featurestories/2007/march/20070320tbanywherewtbday

In sum, global health is not clearly on the Dutch health agenda and therefore it does not get enough attention. The Dutch Ministry of Foreign Affairs focuses on SRHR, while the Ministry of Health, Welfare and Sports is mainly committed to drawing up national policies and as a result, many global health issues fall between two policy tools. Adopting a joint global health strategy, together with other relevant ministries would do justice to the many current global health challenges.

4.3. Millennium Development Goals and Future Sustainable Development Goals

2015 is the year the Millennium Development Goals (MDGs) transition into the Sustainable Development Goals (SDGs) which will be launched at a UN summit in September 2015. Reducing child mortality, improving maternal health and combating HIV and Aids, malaria and other diseases are the health goals among the eight MDGs. One of the proposed SDGs has a broader health goal compared to the MDGs; 'ensure healthy lives and promote well-being for all at all ages' (goal 3) (United Nations General Assembly, 2014). The MDG agenda was considered important as it focussed the development cooperation policies of donor countries, including the policies of the Netherlands. The experts mentioned the following examples: the Dutch contribution to GAVI and to UNAIDS, the role of PharmAccess, the Health Insurance Fund covering HIV/Aids, tuberculosis and malaria, and the Dutch contribution to innovative product development partnerships (PDPs). SRHR was mentioned as an area where the Dutch have an important added value in the international arena, especially as the Netherlands has constantly paid attention to the more controversial issues like sexual education, anti-conceptives and LGTB. One interviewee questioned the foundations of the MDGs and argued that the MDGs were too narrowly defined and donor-driven. This is line with some general critiques of the MDGs (see also Spitz, 2012). Moreover, it was pointed out by one expert that the MDGs have had a negative impact on health systems in receiving countries as these countries have directed their resources to the donor-supported areas and they have neglected other parts of the healthcare systems.

Generally, respondents felt that formulating new targets in the field (global) health as part of the SDGs was important, while some respondents feared that there will be less attention for health in the post-2015 agenda. Because the number of goals is likely to increase from 8 to 17, with only one goal focusing on health and wellbeing, the new agenda might be less focused on health and may lose the 'power of simplicity'. Respondents welcomed the fact that the SGDs are also applicable to higher-income countries and some referred to the many challenges the Netherlands faces such as the economic sustainability of our health system, the threat of NCDs, as well as SRHR issues in the Netherlands (e.g. illegal practices within prostitution, human rights and gender equality). Interviewees expected the Netherlands to maintain its SRHR and right-based focus in the negotiation phase where new goals will be defined and formulated. Views differed as to whether this is the right approach to take; some interviewees did not consider a SRHR focus problematic, because of its close link to MDG5 (improving maternal health) which lags behind (United Nations, 2014). SRHR issues are moreover related to broader goals such as gender equality and education. Others welcomed the current proposed SGDs and argued that the Netherlands should not focus on or lobby for specific topics such as key populations or, for that matter, SRHR. SRHR could still be part of these wider

goals. In sum, while the achievements of the Netherlands in contributing to the health-related MDGs was generally acknowledged, most experts felt the Dutch government should not specifically lobby to address SRHR within the new agenda. SRHR could still be part of a broader formulated health goal.

4.4. Involving the private sector and current policy on aid and trade

The combination of aid and trade is now an integral part of the Dutch aid policy, following policy changes introduced by former State-Secretary of Development Cooperation, Ben Knapen. Development priorities are now aligned with Dutch expertise and foreign interests (Spitz, Muskens & Van Ewijk, 2013). With the establishment of a Minister for Foreign Trade and Development Cooperation in 2012, the link between aid and trade was further formalised. That position was created with the objective to both stimulate development in developing countries, while promoting the Dutch private sector at the same time. To what extent is the focus on aid and trade included in the Dutch policies on global health?

While aid priorities related to water and food security have a very clear link to trade, there is not much attention for trade in relation to global health policies, according to most interviewees. An oft heard explanation is that the Dutch aid policy focus on SRHR provides limited possibilities to stimulate trade as a rights-based and advocacy approach is central. Therefore there is not much to export or market abroad. Nevertheless, there is an enormous potential to connect aid to trade in within a wider global health agenda. According to almost all experts interviewed, the Netherlands has a lot to offer when it comes to improving healthcare in developing countries. The Dutch knowledge and experience with regard to the local organisation of health systems, the control of NCDs, e-health innovations, and the ability to offer holistic health concepts were mentioned as typical Dutch strengths (see also Broere & van Diemen 2013). This is also reflected in the high number of foreign delegations who want to learn about the organisation of Dutch health systems; for instance missions from Brazil and India have visited Dutch hospitals to learn about innovative health programmes in the Netherlands. The innovative Dutch ‘village’ for people suffering from dementia, Hogeweyk, attracted over one hundred missions in 2012 alone (Stam, 2013; see also Box 9). Developing countries facing NCDs could draw on these practices and adapt them to fit into their domestic context. It should be noted that so far there is little evidence of the impact of the Dutch policies that aim to connect trade and aid. As a result, knowledge about the long-term impact of the role of Dutch private actors in relation to health is also limited.

Box 7. Top Sector Life Sciences and Health

The trade potential of the Dutch health sector is also acknowledged by Minister Ploumen and the Netherlands Enterprise Agency (RVO) and is reflected in the establishment of the Top Sector Life Sciences and Health (LSH). The Dutch government has designated the LSH Top Sector as one of the nine top sectors (industries) that bolster Dutch economic strength. LSH focuses mostly on stimulating the export of the Dutch health industry. Although some interviewees mentioned that there is little attention for developing countries within LSH, the Top Sector does identify priority countries in Africa; all of them are emerging African economies. These are Ethiopia, Kenya, Tanzania, Mozambique, Ghana and South Africa. Within these countries the Top Sector focuses on the (re)construction of hospitals (health infrastructure), medical technology, medical knowledge, and education (mother-child care, NCDs and communicable diseases) and biotechnology (vaccines) (De Jong, 2013). Some experts mentioned the possibility of placing communicable diseases higher on the agenda of the Top Sector Life Science and Health.

Public-private partnerships

The Government underlines the importance of public-private partnerships (PPP) in the field of global health, in line with the general focus of aid and health policies. Health is therefore also a topic within the Developmentally Relevant Infrastructure Investment Vehicle (DRIVE), a new financial instrument for public infrastructure that will be launched in the spring of 2015. The Dutch Medical Credit Fund (a fund that works together with African banks to provide credits to African health clinics) and Philips Medical are other recently launched partnerships. Together they develop medical technology that is adapted to resource-poor settings (Henma Publishing, 2014). Most interviewees considered public-private collaboration in the field of global health crucial, but some also expressed concerns about this approach. They argued the government should not 'outsource' health programmes through PPPs, but should rather participate as a full-fledged partner, or at least as a committed facilitator of such collaborations. Donor governments can play an important role in high-risk settings, by (in part) protecting private investors against the risks of financial losses, as well as ensuring that private investment leads to successful and equitable health services and programmes. The role NGOs can play, because of their local network and experience organising healthcare in resource-poor settings, was also mentioned.

Box 8: Successful Dutch health innovations

The Netherlands has enabled many health innovations that have received international recognition. Ronnie van Diemen, the Dutch Inspector-General for Health Care, who oversees 40.000 care organisations in the Netherlands, praised the Dutch power to innovate. For instance, the mentioned nursing home Hogeweyk is a place where people with dementia can live a seemingly normal life in a small village with shops and 'normal' houses and where care providers wear regular clothing. As a result, patients do not really notice that they are sick and dependent; instead they thrive in a safe and healthy environment. Another successful example of organising care is Parkinsonnet; a network of almost 3000 specialised health practitioners at different care levels (from neurologists to physiotherapists and nurses), who work together to provide Parkinson patients with specialised care. The network serves as an example for care providers outside the Netherlands (Munneke & Bloem, 2014).
The Netherlands has also produced several successful e-health solutions. An example is the holiday-doctor; an application (developed by insurance company Achmea) that enables Dutch travellers to consult an online practitioner about their health problems. Based on the advice, they can then decide whether they should see a local doctor or not. There are also e-health innovations that enable diagnostics via online or mobile communication; for instance the application that reviews radiographic images (Delft Imaging Systems). E-healthcare is particularly interesting for resource-poor settings as it enables diagnostics and treatment of patients via online communication. Because mobile phones are much more common in Africa than laptops or computers, these innovations are also known as 'm-health'. The NGO Amref Flying Doctors, for instance, developed an internationally awarded mobile-learning project for nurses and midwives in Kenya, Tanzania and Uganda (Amref, no date). Jacobs (2015) emphasises the importance of international collaboration in this field: 'Developments in medical technology go beyond country borders and therefore require international and European agreements'.

Most respondents observed gradual and positive shifts in the relationship between the government and the business community, indicating that the Dutch aid for trade policy is maturing. The importance of strengthening the local private sector in partner countries was mentioned. It can be very effective to organise health privately, especially in those countries where government systems are insufficient or not in place. As one respondent put it: 'we tend to forget that most of the healthcare in the Netherlands is also privately organised.' It should be noted this is strictly arranged without profit-making objectives. Furthermore, they pointed to the limitations of the private sector, as not all health-related issues can be arranged privately. National governments and the international community should address neglected diseases, for instance, as they are unlikely to be addressed in an economical profitable manner. Also the specific domestic context needs to be taken into account. A market-based approach in organising healthcare carries the risk of excluding the poorest groups, as they often do not have the means to make healthier choices or pay for healthcare.

A broad focus on global health was thus perceived to produce many opportunities for the Dutch private sector, while at the same time improving healthcare in developing countries. Several promising initiatives and PPPs have been initiated and the aid and trade connection is maturing, However, there is still limited knowledge on the effectiveness of these initiatives.

4.5. Research & Development

'Global Health 2035' included a plea to commit more development aid for research & development (R&D) programmes, especially related to the development of global health institutions, and to improve the financial and institutional capacity for R&D. Although respondents acknowledged the importance of research for global health, they stressed that investments should preferably go to applied research in order to improve the effectiveness and implementation of interventions and healthcare products in developing countries. Cross-sectoral partnerships could contribute to this aim, for instance by strengthening business-led health innovations through collaboration with NGOs in 'translational research'; the research phase in which research results are adapted to practice. The general opinion was that a wealth of knowledge already exists on how to deal with common health problems in developing countries. It is the local application of this knowledge that is lacking. Specific areas that need more fundamental research were also mentioned, especially in the field of neglected and tropical diseases. This is an interesting observation because the Dutch policy on R&D in relation to global health already focuses on 'neglected diseases' that require more fundamental research, for instance through the Product Development Partnerships Fund (Ministerie van Buitenlandse Zaken, 2014a). The development of vaccines, especially for tropical and poverty-related diseases such as malaria was mentioned as an area that requires further research. The Ebola crisis has shown that swift political decisions can be taken to invest more in the development of vaccinations. Minister Ploumen, for instance, decided to increase the Dutch contribution to GAVI, because of their efforts to develop an Ebola vaccine (Rijksoverheid, 2015a). Such political decisions always come at a price as it means that less funding will be available for research on other health issues, as some experts warned. This is in line with one of the more general criticisms expressed in 'Global Health 2035': prioritising specific health targets leads to diminishing funds, resources and attention for other issues.

Box 9: Examples of R&D partnerships – AHTI

In 2014, the Amsterdam Health and Technology Institute became a top institute for global health in the capital. This new knowledge institute is the result of a partnership between the Amsterdam Institute for Global Health and Development (AIGHD), Duke University (Durham, North Carolina, USA) and the City of Amsterdam. They work together with, among others, Dutch Universities (VU University, Amsterdam;

University of Amsterdam and Twente University) and the Amsterdam Medical Centre. Its aim is to improve urban healthcare by developing and testing innovative healthcare solutions in an urban environment (so-called 'living labs'). Similar living labs have been set up in Nairobi, Durham and Shanghai. With urbanisation on the rise, it is crucial to improve the understanding of urban health problems and to develop healthcare innovations that are suitable for urban situations.

For more information visit www.ahti.nl

4.6. Future perspectives and missing topics

Global health in general deserves more attention in Dutch policy making, according to the health experts interviewed. Several interviewees expected that the need to tackle and prevent pandemics is likely to receive more attention in the coming years. However, there were also more sceptical views. Because previous pandemics like SARS and MERS did not clearly lead to a change in policy making, there was doubt whether Ebola would lead to structural changes. Most health experts mentioned the need to strengthen health systems as an important future subject. This could include enabling recipient countries to build local health systems in line with economic growth, so that they are able to sustain their health systems. Not all experts embraced an increased focus on health systems. Some argued that it is easier to measure the impact of more tangible health investments such as vaccinations, instead of health system strengthening, because it's easier to keep track of investments and impact.

Because the Netherlands lacks clear policies in the field of global health, let alone a global health strategy, several topics do not receive enough attention in the current discussions on global health, according to the health experts. The interviewees argued that the Dutch government underestimates the urgency of NCDs and antimicrobial resistance. Specifically, obesity, physical inactivity and changing lifestyles were mentioned as important topics directly related to NCDs, which are hardly mentioned in current discussions. To illustrate the magnitude of the problem, one expert said that 50 per cent of all deaths in the world are related to chronic illnesses and 80 per cent of this burden falls on developing countries (see also Lancet Commissions, 2013). A few experts mentioned mental health and geriatrics as health issues that should receive more attention.

Other topics that are currently not included in the discussion, are public health innovation and intellectual property rights (patents). Everyone was aware of this 'big elephant' in the room, but no one talked about it, as one interviewee puts it. The financing of medicines and health facilities was also considered crucial, because there is not enough funding to deliver health facilities, as was also discussed in 'Global Health 2035'. Related to this new innovate forms of financing and the 'delinking' of investments through the marketing of products could assist the delivery of health facilities. Using Official Development Assistance (ODA) as a leverage tool to attract more private money to finance healthcare (blending) was also mentioned.

Some experts perceived issues such as inclusiveness and - related to this - inequality, human rights, and attention for minorities and people with limited chances such as people with a disability as topics that did not receive enough attention, while they are also not thoroughly discussed in 'Global Health 2035'. During the period when this research was being carried out, the Dutch Minister of Foreign Trade and Development Cooperation was in the process of drafting a policy brief to the House of Representatives that focused on promoting inclusiveness in the Dutch policy agenda on trade and international cooperation, for which online consultations were organised.[6]

[6] http://includeplatform.net/consultation-main/opportunities-inclusiveness-trade-international-development/

Box 10: Opportunities for specific actors

How can the Netherlands and specific actors tackle global health challenges and how could they make use of opportunities? Based on the findings of this report and especially the interviews with experts in global health the following general opportunities to address global health in the Netherlands can be identified:

- **Policy coherence** is an area that deserves more attention. This applies to policy coherence between European donor states, as well as policy coherence between national ministries.
- **A multi-actor approach** is needed to improve global health, whereby the specific strengths of each actor can be utilised. For instance, innovative approaches emanating from the private sector can be become more successful when NGOs with specific knowledge and networks are involved.
- **Making better use of an exchange of knowledge** between the Netherlands and especially middle-income countries, as the former is faced with challenges like maintaining the affordability of healthcare, whereas the latter is experienced in providing low-cost health solutions
- **Showcasing good Dutch practices and healthcare interventions abroad** as the Netherlands is known to have one of the best healthcare systems in the world.

The following opportunities were identified for various actors:

International organisations: The WHO should be strengthened, both organisational and budget wise. Donor countries should step up their commitment and commit more resources without earmarks. Experts argued that the WHO should focus on some key areas. Richard Norton, editor-in-chief of the Lancet noted that, 'according to the Economist, instead of doing the job of governments, [the WHO] should focus on the things they cannot manage alone, like helping poor countries to set up health systems, disseminating the best medical research and policies, and combating global epidemics' (Horton, 2015).

European Union: According to the literature there is no clear common global health vision or definition of global health within the EU and the policy community is rather fragmented (Steurs, Van de Pas & Van Belle, 2015; Aluttis, Krafft, & Brand, 2014). However, the interviewed health experts mentioned the European Union (EU) as an important actor to coordinate global health issues (European Commission, not dated). One expert mentioned the possible role the EU could play in making the available knowledge within Europe accessible to lower-income countries.

Role of Dutch government: The Netherlands could benefit from developing a global health strategy in which different ministries cooperate and various stakeholders are involved. There are several examples of other European countries which the Netherlands could draw on. Moreover, the current SRHR focus could be widened, in order to make space for investments in resilient health systems. Previous policy documents have identified this as a relevant issue. Moreover, the Ministry of Foreign Affairs recently selected a consortium as part of a new grant framework that focuses on this connection. The Ebola outbreak has shone a light on the possibilities of proper inter-ministerial collaboration. This collaboration could be sustained and expanded to cover wider global health issues.

NGOs: Most NGOs working on health, focus on SRHR, while few focus on broader global health issues. The role of NGOs was acknowledged as important, because of their local networks and knowledge and also for the implementation of health projects (like the programmes of Cordaid and PharmAccess). However, NGOs were generally not perceived

as critical watchdogs. Instead they mainly follow the priorities set out by the Ministry of Foreign Affairs, because the government provides a large share of their funding. NGOs could play a stronger watchdog role in relation to the social agenda and the global health agenda.

Knowledge institutions: The Netherlands host several knowledge institutions focusing on global health like the Royal Tropical Institute and the Amsterdam Institute for Global Health and Development and Rotterdam Global Health Initiative. Respondents considered implementation research most relevant in the field of global health and knowledge institutions can play an important role in this respect. The experts felt that many solutions are already existent, but have not been made applicable, affordable, or accessible for developing countries yet. Knowledge institutions and research funding agencies can contribute to creating health solutions that work in resource-poor settings. Fundamental research on neglected and tropical diseases is crucial because there are many victims in developing countries, but they are less likely to be funded privately.

Private sector: the private sector is identified as an important actor within the field of global health. Not only because the private sector is playing an increasingly important role in Dutch development policy, but also because it has the ability to catalyse innovation and is able and willing to invest in health. In the Dutch health industry, there is a lot of knowledge of and experience in a broad range of topics; from biotechnology to insurances. Several successful PPPs have proven that collaboration between the private sector and other public and private actors can yield substantial health benefits. This, however, requires taking risks because investments in global health will not always produce profit immediately. Partners should be willing to work together to share and limit risks where possible. The need for financing and innovation from the private sector was widely acknowledged, as well as the proven potential of public-private partnerships in the health sector and the added value of collaboration between the health industry and NGOs. Respondents nevertheless had mixed views about the extent to which ownership of global healthcare should remain with governments or whether it should be (fully) privatised.

This chapter discussed the views of Dutch global health experts on the Dutch global health policy and the recommendations in ‘Global Health 2035’. Although the experts, who have varying backgrounds (see annex 1 for an overview) expressed diverse views on the Lancet’s recommendations and Dutch global health policy in general, several commonalities could be identified. These include the view that global health is fragmented as a policy topic, that policy could benefit from an increased focus on health systems, and that a coherent global health strategy is lacking. Moreover, the experts emphasised the potential value of the Dutch knowledge, expertise, and products/services in the field of global health. It was felt that the Dutch health sector can contribute substantially to improving global health in general. According to the respondents this potential should be utilised more because it could contribute to the enhancement of healthcare abroad, while it also could provide multiple benefits to the Netherlands; both in terms of better healthcare abroad and here, as well as in economic terms.

5. THE DUTCH ATTITUDES TO AND KNOWLEDGE OF GLOBAL HEALTH

5.1. Introduction

'Global Health 2035' stated that improving global healthcare is also the responsibility of the international community and that official development assistance (ODA) should be spent on global health issues. ODA is a part of the government budget of donor countries, so it is public money. In that sense, it is important to know to what extent citizens support ODA expenditures on global health. Studies on the perceptions of the Dutch reveal that a relatively large part of the Dutch population supports governmental spending on healthcare in developing countries. Together with other popular subjects like access to education and clean water, health is traditionally highest on the list of top priorities within foreign aid. A 'Eurobarometer' study in 2014, for example, showed that healthcare was placed place at three out of fourteen future development policy priorities (European Commission, 2013). A poll held in 2013 furthermore revealed that 88 per cent of the population considered it (very) important that the Dutch government spends money on healthcare in developing countries (NCDO, 2013). But what are the main priorities *within* this policy area according to the Dutch? What is, in their view, the major challenge facing global health today? Do they mainly prioritise national health problems such as cardiovascular diseases, cancer and the increasing costs of healthcare? Or do they also care about more global issues like malnutrition and poor access to healthcare in other (poor) countries? In order to answer these questions, we asked 1,057 respondents about their opinion on global health issues.[7] In this chapter we provide an overview of the Dutch attitudes towards global health, while also comparing their views to the recommendations of 'Global Health 2035' and the views of the experts who have been consulted for this report.

5.2. Both local and global problems are seen as major challenges

Within the topic of global health, poor access to healthcare facilities is perceived by the Dutch as the most urgent problem (41 per cent)[8]. This top priority is followed by the number of people worldwide that are underfed (36 per cent). These are both poverty-related health problems. The spread of communicable diseases like HIV/Aids (35 per cent) and emerging NCDs like cancer and cardiovascular diseases (34 per cent) follow at close distance. A cluster of issues that is considered as top priorities by a quarter of the Dutch public, concern the increasing costs of healthcare (26 per cent), antimicrobial resistance (26 per cent)[9] and the increasing number of obese people (23 per cent).[10] Of less concern are maternal and infant mortality (15 per cent) and food safety (11 per cent). Even fewer people prioritise parents who refuse to vaccinate their children (7 per cent) and diseases caused by environmental pollution (6 per cent). The relative low priority that the Dutch award maternal and new-born deaths seems striking. Improving maternal health and reducing child mortality, are two of the eight Millennium Development Goals (MDGs). These MDGs have had a strong influence on the agenda of donors all over the world, including that of the Netherlands. Improving maternal care and reducing child mortality are also among the top priorities where 'a grand convergence' can be realised as identified in 'Global Health 2035'. At a first glance, the international attention for combatting maternal and new-born mortality does not seem to tally with the priorities identified by the Dutch public. However, when we look at an additional question, a different picture emerges. Despite the relatively low policy priority, still 49 per cent say they support spending by the Dutch government on

[7] The data of the 1057 respondents are weighted according to gender, age, region, education and size of family to arrive at a representative sample of the Dutch population

[8] The category 'poor access to health care' did not specifically target lower and/or middle income countries.

[9] A 'Eurobarometer' study held in 2013 shows that 94 per cent of the Dutch population is aware of the fact that unnecessary use of antibiotics leads to resistance (European Commission, 2013).

[10] It should be noted that obesity is directly related to non-communicable diseases, as being overweight, for example, increases the risk of a heart attack.

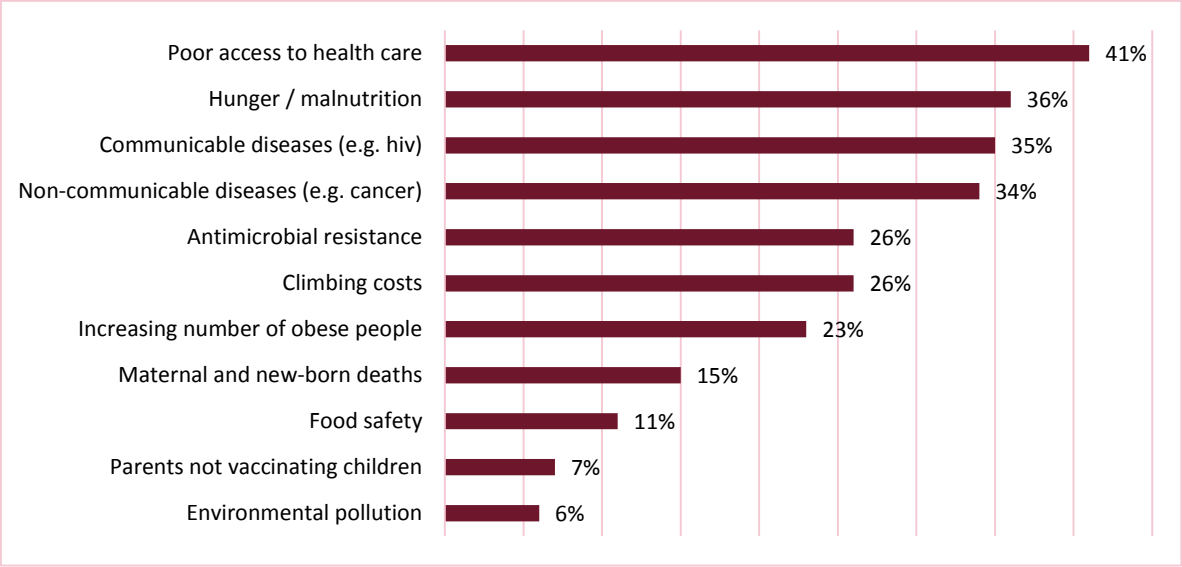

Figure 3. In your opinion, what is the biggest problem facing global health nowadays? (max 3 answers) n=1057.

the provision of prenatal care in underdeveloped countries. So low *relative* support when the topic is mentioned among a list together with other global health issues, doesn't mean there is no *absolute* support for combating maternal and new-born deaths.

In sum, both 'traditional' health problems (e.g. malnutrition) and more recent concerns (e.g. antimicrobial resistance) are acknowledged as issues that are currently challenging global health. The priority list furthermore represents a mix of problems abroad and problems more close to home. In line with the issues raised in 'Global Health 2035', Dutch citizens worry about the spread of communicable diseases and the rise of non-communicable diseases. The Dutch thus by no means focus only on self-interest, by only prioritising pressing domestic problems such as cancer and increasing healthcare costs.

5.3. Healthcare is seen as a universal right

Dutch healthcare is often cited as being one of the best in the world. According to the Euro Health Consumer Index (EHCI), the Netherlands is even number one on the list of healthcare within Europe (Health Consumer Powerhouse, 2015). All Dutch citizens have to have a mandatory basic health insurance, covering all primary care. Other (long time) care is covered by social insurance funded from taxation. This Dutch insurance system is based on the principle of solidarity and insurance premiums are not allowed to be based upon health status or age. Do the Dutch feel that people in other countries also 'deserve' a good healthcare system? The Dutch largely support the importance that the consulted experts and 'Global Health 2035' placed on health system strengthening as they acknowledge that access to sufficient healthcare systems is a universal right. Eighty per cent agrees with the statement that people in poor countries should have equal access to a healthcare system comparable to the Netherlands (see figure 4).

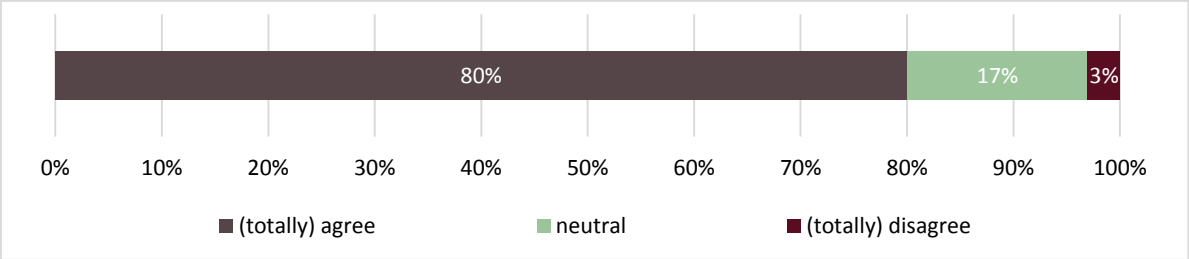

Figure 4. "People in poor countries should have equal access to a healthcare system comparable to the Netherlands" (n=1057)[11].

Furthermore, another 75 per cent is of the opinion that there should be a universal healthcare insurance that ensures access to affordable healthcare for everyone (see figure 5). This figure seems to support the statements included in 'Global Health 2035' on the importance of achieving Universal Health Coverage.

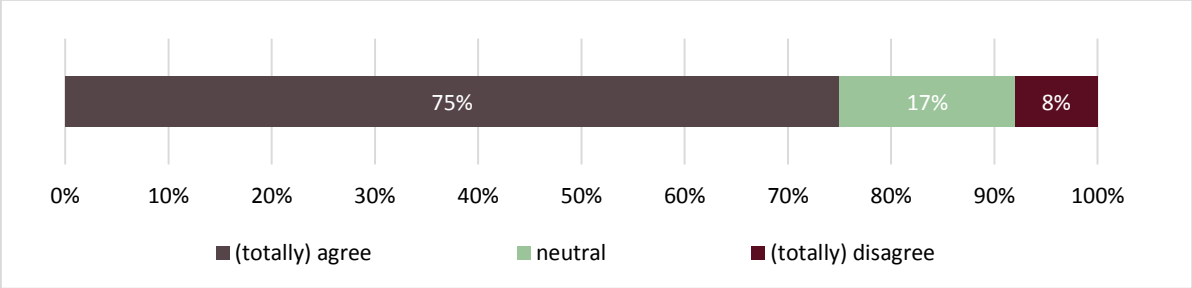

Figure 5. "There should be a universal healthcare insurance that would ensure access to affordable healthcare for everyone"(n=1057).

Not only do poor people deserve equal access to healthcare, half of the Dutch population also thinks that this care should be free-of-charge for the poor in developing countries, which underlines the importance of inclusiveness that some of the experts raised (see figure 6).

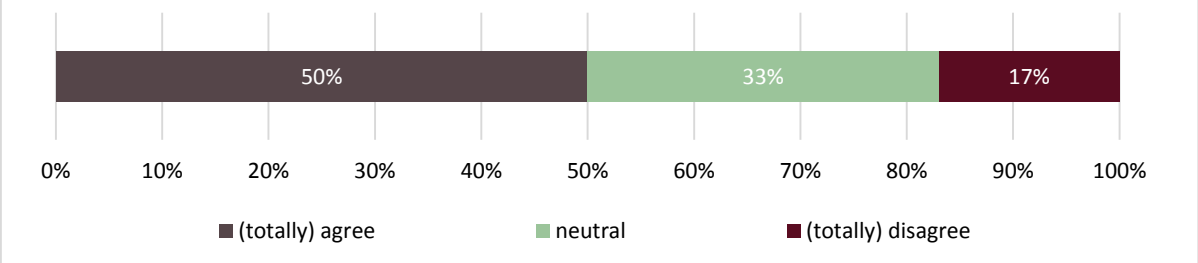

Figure 6. "Healthcare should be free-of-charge for the poorest in developing countries "(n=1057).

5.4. Building health systems is seen as a shared responsibility

'Global Health 2035' referred to the various actors that should make a 'grand convergence' within a generation, if possible. Dutch citizens also regard improving healthcare in developing countries as a shared responsibility for a variety of actors worldwide. First, *pharmaceutical companies* should ensure that the poorest in developing countries have access to medication at affordable prices: 77 per cent agrees with this statement. Furthermore, over half of the Dutch public (60 per cent) views *development aid* as a necessity in order to improve healthcare systems in developing countries. This is in line with the view expressed in 'Global Health 2035'. At the same time, however, this by no means implies that

[11] In order to improve the legibility of all the figures, we created a new category 'neutral', which includes the categories 'don't know/ no opinion' and 'not agree/ not disagree'.

national governments in developing countries should minimise their efforts: 75 per cent agrees that it's the primary responsibility of a state to provide good healthcare to its citizens. Foreign aid cannot be a replacement of a government's responsibility.

5.5. Multilateral organisations most capable actors

'Global health 2035' emphasised the leadership of the WHO in the field of global health and many experts who were consulted have mentioned the importance of strengthening and improving the WHO's role. Dutch citizens also acknowledge the role of the WHO in safeguarding global health. When asked which (international) actor is most powerful in solving problems within healthcare worldwide, the vast majority points to *international organisations* like the WHO (see figure 7). Fifty per cent prefers these multilateral approaches, followed by national (14 per cent) and local governments (12 per cent).[12] This seems to be in line with the weight that 'Global health 2035' attached to the role of multilateral organisations in relation to improving global health.

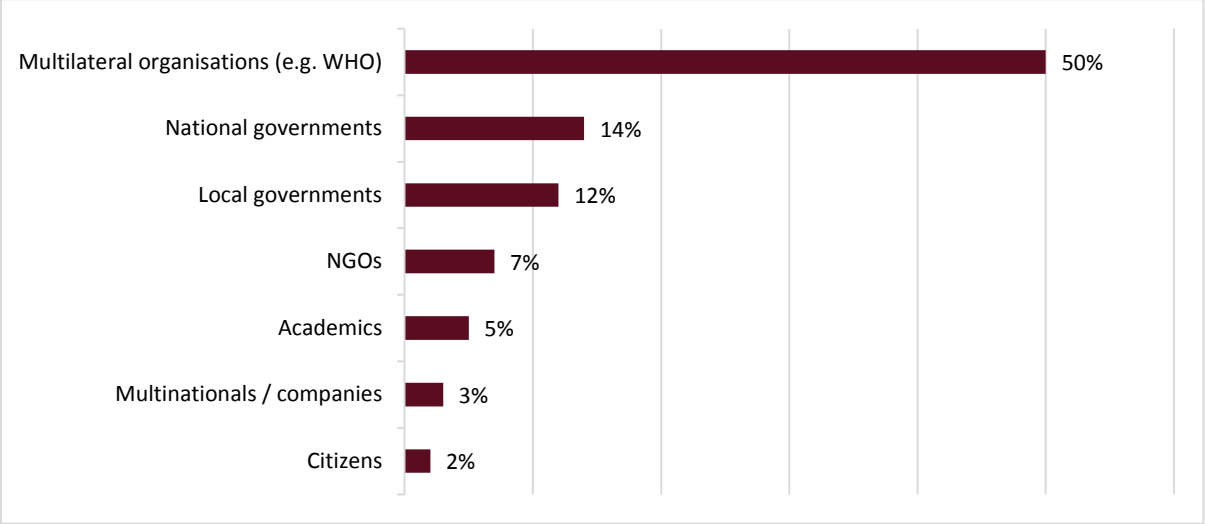

Figure 7. In your opinion, which actor is best capable of solving problems within global health? (choose 1 answer) (n=1057).

5.6. Less support for financial contributions to global health

As seen above, the Dutch support for universal access to healthcare is widespread. However, the Dutch are somewhat more reluctant when asked about their (own) financial responsibility in order to help improving healthcare worldwide. Almost half of the population (45 per cent) agrees that wealthy countries should contribute financially to the improvement of healthcare systems in poor countries. But despite living in one of the wealthiest countries in the world, only a quarter (24 per cent) is personally willing to make a financial contribution in order to improve healthcare in underdeveloped countries.

The gap between general support and the actual willingness to make a personal financial contribution, (charity) or support the contribution by national government (aid), matches previous research findings. Answers to questions on foreign aid that involve a personal financial contribution or spending by the government always show less support compared to more general questions related to support. The acknowledgement of the existence of certain (global) problems doesn't automatically indicate that 'we' should also fund a solution to this problem. This applies especially in times of a national economic crisis (Henson & Lindstrom, 2013). In line with this, figure 8 shows that spending money on health is mostly supported when it also serves the self-interests of people in the Netherlands, by directly protecting the health of Dutch citizens. Funding research programmes aimed at treating and curing

[12] In the Netherlands roles of providing healthcare have recently been transferred from central to local government level.

infectious diseases, for instance, attracts far more support than the combating of HIV/Aids in developing countries.

5.7. SRHR

The same gap between general support and the specific support for spending also occurred when we inquired about the role of the Dutch government in efforts to improve SRHR globally. SRHR is a priority within the Dutch development policy. Focus areas include maternal and prenatal care and combating infectious diseases such as HIV and Aids. As figure 1 showed, the spread of infectious diseases is seen as a top priority within global health (third place out of eleven policy priorities). However, only one out of three (35 per cent) supports governmental spending on combating sexually transmitted diseases like HIV and Aids in developing countries (see figure 8). A comparable group (34 per cent) supports funding for reproductive health and education. There is more support for improving maternal care: one out of two (49 per cent) supports governmental spending on access to good prenatal care for women in poor countries.

This 'mismatch' between the high priority given to the spread of infectious diseases in general and the relative low support for spending on combating HIV and Aids specifically, might also indicate that the high priority provided to the global spread of infectious diseases is influenced by the recent Ebola outbreak, and not so much by a concern about HIV and Aids.

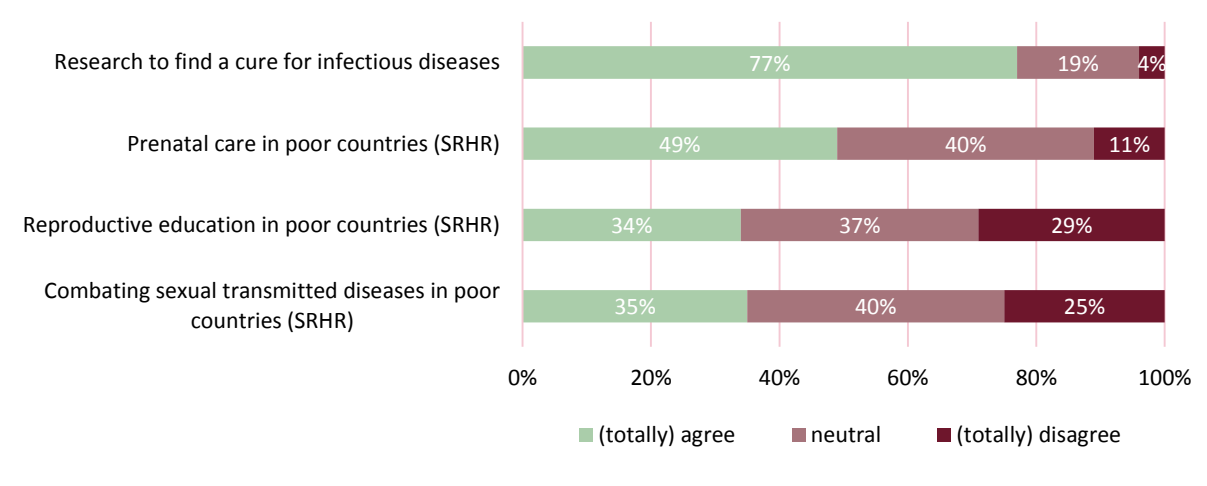

Figure 8. The Dutch government should invest in….(n=1057).

5.8. Half of the population is worried about the global spread of diseases

In august 2014, when there was a lot of attention for the Ebola outbreak, Kaleidos Research carried out a survey on the concern about infectious diseases among Dutch citizens. In that study, half of the respondents said that they feared Ebola would spread to the Netherlands. According to the findings of this survey a comparable group says they worry that infectious diseases will spread to the Netherlands, due to increased personal traffic or through migration flows (see figure 9). They are somewhat less worried about the transmission of diseases through animal transport and the import of meat (41 per cent). It is important to emphasise that this does not mean that the other half of the Dutch population does not worry at all. On average, only about one in four explicitly stated they do not fear the spread of diseases (see figure 9). The concern for the spread of infectious diseases indicates that many citizens are aware that infectious diseases can spread transnationally.

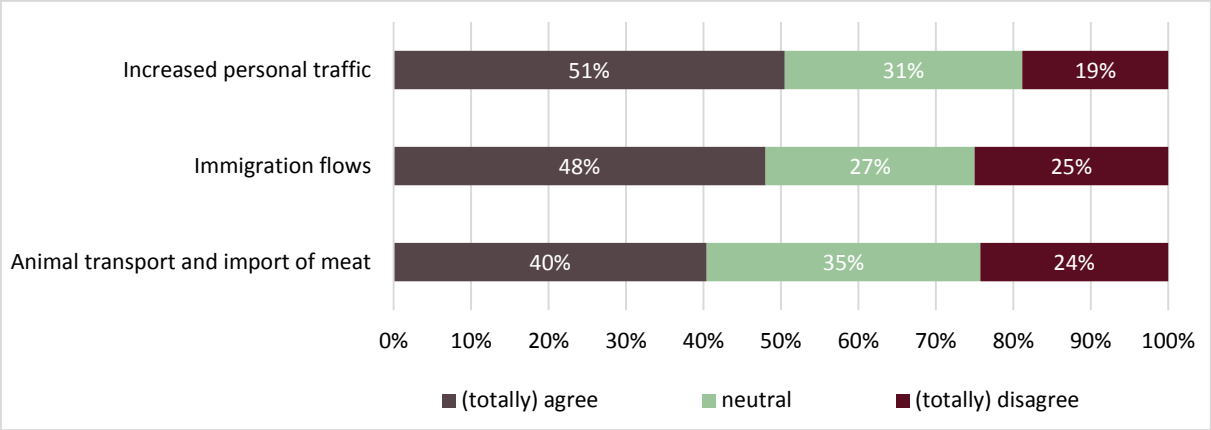

Figure 9. I worry that diseases will spread to the Netherlands due to …..(n=1057).

Box 11. Differences between opponents and supporters of foreign aid

It is important to note that there are considerable differences in opinions about global health issues between different groups in Dutch society. These differences are a reflection of overall differences between opponents and supporters of foreign aid in general. Opponents of foreign aid (15 per cent of the population) have different priorities compared to those in favour of foreign aid (39 per cent of the population). The biggest difference between these two groups is the priority they award to poor access to health and malnutrition. According to opponents of foreign aid, these issues are not major problems within global health (respectively place five out of 11 and place seven out of 11), while they were perceived as priority issues by supporters of foreign aid. Opponents place more emphasis on domestic issues: the top three concerns are chronic diseases like cancer, the global spread of infectious diseases and obesity. Moreover, despite a bigger fear of the global spread of infectious diseases, they show less support for governmental spending on global health. However, even if we disregard the opponents of foreign aid, the general support for spending on global health remains relatively modest. For example, disregarding the opponents of foreign aid, increases support for funding the fight against the spread of sexual transmitted diseases by only 5 per cent (from 35 per cent to 40 per cent).

This study underlines the importance the Dutch public bestows on healthcare within the foreign aid agenda. It indicates that Dutch citizens are aware of several of the concerns raised in 'Global Health 2035', such as the rise in NCDs and the quality of health systems in developing countries. Malnutrition and poor access to healthcare are perceived as the two top priorities within global health, while relatively not as much priority is given to SRHR-related topics, such as reproductive education. However still half of the population supports government spending on prenatal care. In line with the recommendations made in 'Global Health 2035', sufficient and affordable healthcare for all is considered a universal right, which requires the commitment from various actors all over the world. Based on these results, support for global health issues seems to be mainly morally motivated. However, a different picture emerges when it comes to funding global healthcare. The importance awarded to universal healthcare does not necessarily reflect the support given to actual spending by the Dutch government. Spending is most supported when self-interests are evident, like finding a cure for infectious diseases. It is not clear to what extent the Dutch public acknowledges the *transcending* dimension of health issues and whether the Dutch public thinks that 'far away' issues also have an

direct impact in the Netherlands. There is one exception: the transmission of infectious diseases. The majority of the population fears the transmission of these diseases and three out of four supports funding to find a cure. The recent Ebola outbreak in 2014 undoubtedly contributed to this awareness.

6. CONCLUSIONS

This report draws on the conclusions of the Lancet Commission for Investing in Health (hereinafter called 'the Commission'). We have investigated the extent to which the report 'Global Health 2035: a world converging within a generation' (hereinafter referred to as 'Global Health 2035') impacted the discussion and policies on global health in the Netherlands. The report also discusses the extent to which global health is on the agenda of Dutch policy-makers and includes the views of Dutch citizens on global health issues. In this concluding chapter we will integrate the different findings (desk research, the interviews with experts and the survey among Dutch citizens) and compare the findings to the main issues in 'Global Health 2035'.

Health and healthcare are heavily debated issues in the Netherlands and one of the main focus areas of Dutch domestic policy; around one-fifth of the government budget is spent on national care and health. Curbing the rising healthcare costs is one of the most pressing national challenges. Global health, however, receives only a fraction of the attention; both in terms of public debate and in terms of finances. The lack of attention for global health issues is also reflected in policies. Unlike other European countries such as the United Kingdom and Sweden, the Netherlands has no overarching global health strategy.

Currently the Dutch Ministry of Foreign Affairs is mainly focusing on a specific section of global health, namely sexual and reproductive health and rights (SRHR). Within development aid, the Netherlands also focuses on combating infectious diseases; it invests in vaccines, and is an important donor to the Vaccine Alliance (GAVI) and the Global Fund. By doing so, the Netherlands has become an important contributor to combating mother and child mortality and controlling infectious diseases. However, the focus is not on combating the emergence of non-communicable diseases (NCDs) and achieving universal health coverage (UHC) in developing countries, which are also key areas according the Commission. The Ministry of Health Welfare and Sports in turn is mainly focused on health issues in the Netherlands, as this falls within the mandate of the ministry and it has little attention for international health issues. The ministry does focus on antimicrobial resistance, which is clearly a health issue with many transnational interlinkages. According to the interviewed health experts, other transnational health issues that are becoming increasingly urgent, fall more or less in between the two ministries. As a result, policies are more reactionary and geared to providing emergency assistance, instead of ensuring the Dutch policies are well-adapted to current and future global health challenges. The latter is very important, as the Netherlands is particularly vulnerable as an open trade-oriented economy.

6.1. 'Global Health 2035'.

In 2013, the commission published its report 'Global Health 2035'. Both the commission itself and the Dutch health experts considered the publication of the report to be timely, as this was only two years before the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs). However, in the Netherlands the attention for the report has been negligible. Few people have actually read the report and it has not been picked up by politicians or policy makers. This is noteworthy, as the report did receive a lot of international attention and even triggered some European countries, such as the United Kingdom, Sweden and Norway, to draw up or adjust global health strategies.

6.2. Achieving a grand convergence in global health

According to 'Global Health 2035', tackling infections and neglected tropical diseases and improving maternal and child health conditions will best be achieved in most countries through health system

strengthening (HSS) and scaling up new and existing tools. The international community can support this by financing research and development; providing transitional financing to a select group of countries; tackling antimicrobial resistance; supporting pandemic preparedness, and by supporting capacity building within international institutions.

To what extent are these issues on the Dutch global health agenda? The Dutch government has invested in improving maternal and child healthcare, as part of its SRHR focus. Moreover, the Netherlands is also a strong supporter of health-related research and development (R&D), as exemplified by the 'PDP Fund against poverty-related diseases' and the recent Dutch increased contribution to the Global Fund and GAVI.

Although most experts acknowledged the strength of the Dutch focus on SRHR and the added value it brought to the topic in the international arena; they also pointed out that because of this focus, less attention is paid to wider global health issues, such as HSS. A broader approach to global health would not only provide opportunities to better utilise the potential in the Dutch health sector. It could also contribute to more impactful SRHR-programmes, because well-functioning health systems are a prerequisite for the accessibility of services and goods (e.g. contraceptives) related to sexual health. In addition, experts referred to the importance of HSS for improving global health and controlling diseases like Ebola.

According to the respondents, increased investments in HSS would also be beneficial for the minister's aid and trade agenda and it would increase opportunities for the private sector. The consulted experts emphasised the potential of the Dutch health sector in the field of the organisation of health systems, the control and prevention of NCDs, e-health innovations, and the ability to offer holistic healthcare concepts. Nevertheless, many of the consulted experts stated that the connection between aid and trade that governs Dutch development policy is not explicitly made in relation to SRHR.

The health experts interviewed for this research stated that investments should mostly go to applied research in order to improve the effectiveness and implementation of interventions and healthcare products in developing countries. They did, however, underscore the importance of fundamental research on neglected and tropical diseases. They also mentioned the importance of cross-sectoral collaboration; for instance, the role that companies can play when it comes to health innovations and the added value of NGOs with regard to translational research. Dutch citizens mainly support R&D that can be clearly linked to their own interests, for instance, R&D aimed at treating and curing infectious diseases.

Consideration for antimicrobial resistance and pandemics - another important area of interest to the international community as was addressed in 'Global Health 2035' - was mentioned as one of the topics that requires more attention. All experts welcomed the efforts and support from the Minister for Health, Welfare and Sports to tackle antimicrobial resistance. However, this study highlights a lack of cooperation between different ministries and a lack of structural policy to increase the pandemic preparedness of the Netherlands. One exception mentioned was the collaboration around the recent Ebola outbreak, when the Dutch Ministry of Foreign Affairs, the Ministry of Health, Welfare and Sports as well as the Ministry of Defence worked closely together to achieve joint policies. Most health experts praised the government for its swift response to the Ebola outbreak, but expected the attention to be short-lived. The spread of communicable diseases is also a concern of Dutch citizens; half of them are worried about the global spread of diseases.

‘Global Health 2035’ identified another key area to achieve global health goals: supporting capacity building within international institutions. Dutch health experts recognised this as an important focus area that requires more attention. They emphasised that the WHO’s role is rather weak, but argued that this is not surprising as the budget of the WHO has come under a lot of pressure. Donor countries have both reduced and earmarked their contributions, leaving little room for the WHO to deal with emerging issues. Donor countries, including the Netherlands, should consider strengthening the WHO and they should follow through on their commitments to the organisation, as this is also in their self-interest. Most health experts agreed that the WHO should be fully supported and that the organisation should refocus its attention on core activities, particularly providing technical leadership. The vast majority of the Dutch public also supports the view that the international organisations like the WHO are relevant. When asked which (international) actor is most powerful in solving problems within healthcare worldwide, half of the Dutch citizens feel that particularly global health is an area of responsibility for international organisations, as well as for the respective national governments.

6.3. Curbing non-communicable diseases and injuries

In order to curb NCDs and injuries ‘Global Health 2035’ recommended that the international community should support population, policy, and implementation research; provide technical assistance on taxation, trade and subsidy policies, and provide targeted financing to the poorest countries so they can scale-up certain clinical tools, such as a hepatitis B vaccine and an HPV vaccine.

NCDs were identified as one of two topics (the other being antimicrobial resistance) currently missing in the Dutch debate on global health. Experts stated that the urgency of these issues is underestimated. Injuries were only mentioned by a few experts. The Minister for Foreign Aid and Development Cooperation has highlighted access to vaccinations against preventable infectious diseases and the introduction of new vaccinations such as the HPV vaccine against cervical cancer (the most deadly form of cancer for women in sub Saharan Africa). This falls within the focus on SRHR and is in line with domestic policies. Dutch citizens also supported attention for the emergence of NCDs; chronic illnesses were considered one of the most imminent health challenges worldwide.

6.4. Achieving universal health coverage

‘Global Health 2035’ suggested two pro-poor pathways to achieving UHC within a generation and recommends that the international community should support health systems research, and finance both the institutions for revenue mobilisation and population, policy, and implementation research. The interviewed experts embraced the report’s emphasis on UHC, but they agreed there is a very limited focus on this topic in Dutch development policy. The latter is striking, as health insurance in the Netherlands is mandatory and covers the costs of basic healthcare. It was widely recognised that the Netherlands has a lot of expertise to offer in the field of health systems; from the organisation of primary healthcare, to insurance systems and smart e-health systems. At the same time, health experts agreed that the Dutch could also benefit from exchanging knowledge with emerging economies, because the Netherlands faces major domestic challenges in the field of health, mainly the affordability of the Dutch healthcare system.

Dutch citizens clearly look beyond their own borders when asked about health issues; poor access to healthcare worldwide was considered the most urgent health problem; 41 per cent of Dutch citizens mentioned this topics and 80 per cent even feels that poor people should have access to healthcare systems comparable to the Netherlands. Related to this, nearly half the population feels that higher-income countries should also contribute financially to stronger health systems in lower-income countries. Spending on global health by the Dutch government was however, mostly supported when the domestic benefits are evident.

In sum, the main conclusion that can be drawn from our findings, is that several global health issues are falling between two stools, as the Ministry of Foreign Affairs is focusing on SRHR and the Ministry of Health, Welfare and Sports is mainly targeting domestic policies, with the exception of antimicrobial resistance. In addition to the global health challenges that fall outside the scope of both ministries, policies are also more reactionary and geared to providing emergency assistance, instead of ensuring that the Dutch policies are well-adapted to current and future global health challenges. Developing a Dutch global health strategy could ensure that various global issues are addressed more systematically and that the potential of the Dutch health sector is put to better use. Experts from different backgrounds emphasised the importance of a more integrated and coherent global health strategy in order to be better prepared for possible future outbreaks of infectious diseases, as well as other global health issues, such as antimicrobial resistance. This is particularly relevant when one takes into account the vulnerability of the Netherlands as an open economy, the urgency of several global health issues and the wealth of knowledge and experience that the Dutch health sector can offer. Moreover, emerging NCDs in lower and middle-income countries require more attention within development cooperation policies, as they are increasingly becoming the main killers. Realising the grand convergence that ‘Global Health 2035’ envisioned is a challenge that will contribute to improving global health, in middle and lower-income countries, as well as in the Netherlands. Nowadays, health issues are not only characterised by their global interconnectedness and the shared responsibility to deal with them, but also by the shared advantages, because healthy people and healthy economies are intrinsically interlinked.

METHODOLOGY

Kaleidos Research carried out this study using three different research methods; desk research, survey research among the Dutch public and semi-structured interviews with 18 key experts from knowledge institutions, national government, political parties, NGOs, and companies.

1. The desk research focused on relevant publications (policy documents and academic literature) from renowned sources. It enabled us to contextualise the empirical findings in this study and to offer the reader a more comprehensive overview of global health. Publications were selected based on their relevance, recentness, and the significance (in terms of the number of times the document is referred to). The desk research did not aim to include all relevant publications, as it is impossible to do justice to all available sources.
2. The semi-structured interviews were conducted in January, February and March 2015. Key stakeholders were identified, using a landscape and stakeholder analysis. The interviews were analysed in a structured and replicable manner; based on literal transcriptions and using content analysis software.
3. The survey was conducted online among 1057 respondents in February 2015, using the Computer-assisted Web Interviewing (CAWI). The fieldwork was done by TNS NIPO (Amsterdam, The Netherlands). In order to have a sample that was representative for the entire population of the Netherlands, the data were aggregated based on gender, age, region, education, and size of family.

Questions about this publication and the research methodology can be directed to the authors through: info@kaleidosresearch.nl

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APPENDIX 1

HEALTH EXPERTS CONSULTED FOR THIS RESEARCH

The following persons have been interviewed as part of this study. They are considered key experts from different sectors that are involved in global health, with a focus on the role and position of the Netherlands:

Scientist/ knowledge institutions

- Frank Cobelens – AMC/ UvA, , Amsterdam Institute for Global Health and Development Foundation
- Cate Hankins – Amsterdam Institute for Global Health and Development
- Mark Geels - Amsterdam Health and Technology Institute (AHTI)
- Godelieve van Heteren - Rotterdam Global Health Initiative
- Louise van Schaik - Netherlands Institute of International Relations Clingendael

Government

- Reina Buijs – Ministry of Foreign Affairs
- Lambert Grijns & Marco Gerritsen - Ministry of Foreign Affairs
- Gert-Jan Rietveld – Permanent Representation of the Kingdom of the Netherlands to the WHO - Ministry of Health, Welfare and Sport
- Marja Esveld – Ministry of Health, Welfare and Sport

Politicians

- Bram van Oijk – Member of Parliament, GroenLinks

Private sector

- Jan Willem Scheijgrond - Philips Medical
- Herbert Schilthuis – Heineken Global Health & Safety
- Frans van den Boom - Topsector Life Sciences and Health

Civil society

- Alexander Kohnstamm - PharmAccess
- Anke Tijtsma - WEMOS

International institutions

- Tormod Simensen - Global Alliance for Vaccines and Immunisation (GAVI)
- Marijke Wijnroks – Global Fund to fight Aids, Tuberculosis and Malaria